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County Hall,
Hertford.
June, 1953.

To the Chairman and Members of the Health Committee.

Ladies and Gentlemen,

I have the honour to present my report as County Medical Officer for the year 1952—the thirteenth in the series.

On this occasion the report takes an unfamiliar form in that it is in two parts. Part II pages 47–107 follows the lines of the traditional Public Health Report. Part I is a survey of the past five years showing how our services have affected, or been affected by, the other elements in the National Health Service. This was written at the express wish of the Ministry of Health who felt that a review of this kind " would be advantageous to central and local government alike ".

The form and scope of the survey was indicated in the Ministry's circular and I have assumed that it would be their wish that I should write at length on items in which our experience might be of value and avoid doing so where it was not. This has resulted in a report which is unbalanced in its emphasis.

I have assumed too that the report should be constructive and, if necessary, critical. If a report of this kind is to have any value it must high light the good and the bad with equal frankness. Having made this point I must hasten to add that my criticisms are made as part of an impersonal study of an administrative machine. It us perhaps only possible for one who is himself entangled in the meshes of the recent legislation to appreciate to the full the work which has been done at all levels to give practical expression to the good intentions which inspired the National Health Service Act and led to many of its complications.

A great deal of the text of Part II is in the form of extracts from Officers reports on their work in 1952. I am indebted to Dr. Stewart for editing and extracting these reports and for writing those items in the text which are not credited to anyone else. My thanks are due too to Mr. Treharne and the clerical staff for their work in making it possible to present a draft of this particularly complicated report to the May meeting of the Health Committee.

I am, Ladies and Gentlemen,
Your obedient servant,

J. L. DUNLOP,
County Medical Officer.

CHAIRMAN OF THE HEALTH COMMITTEE.

G. Rollo Walker, Esq.

STAFF.

(As at 31st December, 1952.)

County Medical Officer.

J. L. Dunlop, M.D., D.P.H.

Deputy County Medical Officer.

W. Stewart, M.B., Ch.B., D.P.H.

County Dental Officer.

A. C. Wilson, L.D.S., R.C.S.

Divisional Medical Officers.

(See also page 7.)

Dacorum.

M. Gross, M.B., B.S., D.P.H., Churchill Park Road, Hemel Hempstead.

South-West Herts.

R. C. M. Pearson, M.D., M.R.C.P.(Ed,) D.P.H., Town Hall, Watford (resigned 21.10.52).

St. Albans.

J. C. Sleigh, M.B., Ch.B., D.P.H., 15 Hatfield Road, St. Albans.

North Herts.

V. R. Walker, M.B., Ch.B., B.Sc., D.P.H., 12 Brand Street, Hitchin.

Welwyn.

G.R.Taylor, M.B.,B.S.,M.R.C.S.,L.R.C.P.,D.P.H., "Breaks," French Horn Lane, Hatfield.

South Herts Division
East Herts Division } No Divisional Scheme in force.

Assistant County Medical Officers.

R. M. Allinson, M.B., Ch.B., D.P.H.
F. Barasi, M.R.C.S., L.R.C.P., D.P.H.
B. E. S. Colman, B.A., M.R.C.S., L.R.C.P.
R. S. Cooper, M.B., B.S.
J. E. Crawley, M.B., Ch.B., M.R.C.P.(Ed.).
M. M. Harwood, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
E. M. Jones, M.B., Ch.B., D.P.H.
L. S. Karpati, M.D. (Graz).
M. S. Miller, B.A., M.B., Ch.B., B.A.O., D.P.H.
D. G. Milne, M.B., Ch.B., D.P.H.
S. J. Moynihan, M.R.C.S., L.R.C.P.
H. E. D. E. Ormiston, M.B., B.S., D.P.H.
M. Ward, M.B., Ch.B., D.P.H.

Chest Physicians.

T. A. W. Edwards, B.A., M.B., B.Ch., M.R.C.P.
A. G. Hounslow, M.D.
N. A. Neville, B.M., B.Ch., M.R.C.P.
P. W. Roe, B.A., B.M., B.Ch.
J. B. Shaw, M.D., D.P.H.

County Consulting Psychiatrist.

H. A. Palmer, M.D., M.B., Ch.B., D.P.M., M.R.C.P.

Honorary Obstetric Adviser.

F. Neon Reynolds, F.R.C.S.(Ed.), F.R.C.O.G. (Died Dec. 1952.)

Honorary Obstetric Analgesist.
J. E. Elam, B.A., M.R.C.S., L.R.C.P., L.M.S.S.A.

Honorary County Ophthalmic Officer.
K. F. Matthews, M.R.C.S., L.R.C.P., D.O.M.S., D.P.H.

County Nursing Officer and Day Nurseries Supervisor.
F. MacDonald, S.R.N., S.C.M., C.R.S.I., H.V., Q.N., M.T.D., T.A

County Health Inspector.
J. L. Stringer, M.R.S.I., Cert.S.I.B.

Senior Authorized Officer.
W. H. Finch.
(Chief Welfare Officer.)

Almoners.
S. Bone, A.M.I.A.
J. R. Horton, A.M.I.A.
M. Howard-Jones, A.M.I.A.
P. Morfey, M.A., A.M.I.A.
M. J. Waghorn, A.M.I.A.

Home Help Organiser
H. M. Watson.

Social Workers, Mental Health.
E. M. Morris.
A. G. Peace.
H. J. S. Taylor., Dip. Soc. Sc.

Organizer of Occupation Centres.
P. E. Rock.

Chief Clerk.
W. A. Treharne, A.C.I.S.

Campions Ante- and Post-Natal Hostel.
Matron : E F Belcher S.R.N., S.C.M.

MEDICAL OFFICERS OF HEALTH AND SANITARY INSPECTORS OF COUNTY DISTRICTS.

(As at 31.12.1952.)

Division.	*District M.O.H.*	*County District.*	*Sanitary Inspector.*
East Herts	Dr. E. M. Jones (A.C.M.O.).	Bishop's Stortford U.D.	Mr. A. L. Good
	*Dr. C. R. Hillis (temporary).	Cheshunt U.D.	Mr. C. Wilson
	Dr. J. Wildman	Hertford B.	Mr. B. Peck
		Hoddesdon U.D.	Mr. W. N. David
		Sawbridgeworth U.D.	Mr. C. A. Ford
		Ware U.D.	Mr. C. J. Lucas
		Braughing R.D.	Mr. E. E. Wateridge
		Hertford R.D.	Mr. H. E. Gilby
		Ware R.D.	Mr. A. D. G. Goold.
North Herts	Dr. V. R. Walker **(Divisional County M.O.).**	Baldock U.D.	Mr. B. W. E. Makepiece
		Hitchin U.D.	Mr. N. Holt
		Letchworth U.D.	Mr. A. Jump
		Royston U.D.	Mr. S. M. Jackson
		Stevenage U.D.	Mr. H. Foden
		Hitchin R.D.	Mr W. M. Matthews
St. Albans	Dr. J. C. Sleigh **(Divisional County M.O.).**	City of St. Albans	Mr. R. E. C. Goddard
		Harpenden U.D.	Mr. W. G. Coker
		St. Albans R.D.	Mr. D. J. Graham.
	*Dr. G. W. Everett (temporary).	Elstree R.D.	Mr. A. D. S. Blackhall
South Herts	Dr. A. L. Hyatt (temporary).	Barnet U.D.	Mr. J. B. Wilson
	*Dr. C. M. Scott (temporary).	East Barnet U.D.	Mr. W. K. Pickup.
South-West Herts.	*Dr. M. Ward (acting).	Watford B.	Mr. R. V. Jacob
	Dr. W. Harvey	Bushey U.D.	Mr. A. C. F. Gisborne
		Chorleywood U.D.	Mr. W. E. Hands
		Rickmansworth U.D.	Mr. C. R. Alexander
		Watford R.D.	Mr. S. N. Grigg
Welwyn	Dr. G. R. Taylor, **(Divisional County M.O.**	Welwyn Garden City U.D.	Mr. M. Stockdale
		Hatfield R.D.	Mr. S. W. Wright
		Welwyn R.D.	Mr. C. B. Borthwick
Dacorum	Dr. M. Gross **(Divisional County M.O.).**	Hemel Hempstead B.	Mr. A. C. Horne
		Berkhamsted U.D.	Mr. C. E. Brogan
		Tring U.D.	Mr. J. F. Norris
		Berkhamsted R.D.	Mr. C. Laidman
		Hemel Hempstead R.D.	Mr. R. H. T. Chappell

* Also holds appointment as part-time A.C.M.O.

Except where indicated, the officers named here serve County District Councils and are not on the staff of the County Council. This list is included in the Report for the information of those interested in the staffing of the Health Services in the County as a whole.

PART I.

SURVEY OF NATIONAL HEALTH SERVICE ACT 1948–1952

Survey of Local Health Services

Administration.

A scheme of Divisional Administration was introduced in this County in July, 1948. The reasons for making this change were :—

(1) There was already in existence a divisional education system.

(2) The increasing population of this County had for some time made it difficult to keep in touch with detail of the services and it was anticipated that with the introduction of the National Health Service, there would be a rapid expansion in the services throughout the County.

(3) The local Sanitary Authorities were demanding an effective share in the administration of the County's services in their several localities.

(4) The National Health Service Act did nothing to bring about an effective link between the services of the Local Health Authority and the environmental services of the Local Sanitary Authority, though there was so much that was complementary in the work of their Medical Officers.

Our original Divisional Scheme provided for six Divisions only because in one of the existing seven Education Divisions there was no hospital and it was held that a Health Division should contain Hospital Services. Ultimately, in response to local pressure from the Division which we had proposed merging with a neighbouring Division, it was agreed there should be seven Divisions co-terminus with those of the Education Authority.

A scheme in the South-West was developed well in advance of the Appointed Day to ensure that there would be no change in the direction of the Watford Borough Maternity and Child Welfare Services which were due to be transferred to the County Council.

The idea of a divisional administration covering both County and local services was introduced to County District Councils as opportunity offered but, in each case, the actual inauguration of the Divisional Scheme has been at the request of the County Districts concerned.

The Scheme is now operating in five of the seven Divisions. In three instances, the Divisional Medical Officer is also Medical Officer of Health of the whole Division. In one instance, he serves three of four District Councils, in another one of five Councils in the Division.

At the outset, there was considerable pressure from District Councils for Divisional Executive Committees with delegated powers but at a meeting with representatives of the District Councils Group, it was shown that Committees would necessarily add considerably to the cost of the scheme. Quite apart from this, they would inevitably lead to a very much more involved and much less flexible administrative structure, whereas a delegation at officer level would be free from these objections, and would, moreover, be a more effective administrative instrument because :—

(1) The County District Councils views could be made known through their Medical Officer of Health direct to the County Medical Officer and to the County Health Committee. With Divisional Executive the views of the District Council would have to be discussed with the County Medical Officer before being put to the Executive Committee and passing to the County Health Committee for a final decision.

(2) The County Medical Officer was given considerable discretion in taking action within the limits of County policy. He had power to delegate responsibilities at his discretion to members of his staff. If, however, there were Divisional Executive Committees it would be impossible for the County Medical Officer and the Divisional Medical Officer together to agree on a line of action without prior consultation with the Divisional Executive and subsequent confirmation by the County Health Committee.

(3) There was little scope for Divisional Committees in operation of the Health Services. Staff employed were mainly responsible technical officers working under expert guidance. Schemes were framed in accordance with County policy. The County Medical Officer could be advised on local variations by Officers with local knowledge—hence the proposal that the Medical Officer of Health should become a member of the County Health team.

(4) Changes in policy were made by the Health Committee on the advice of the County Medical Officer and all financial matters were the ultimate responsibility of the County Health Committee and the County Finance Committee. There was thus nothing in the health organization comparable to the education system in which a Divisional Committee could be given responsibility in the day-to-day management of the schools in their area.

It was freely conceded, however, that the Health Committee must continually have regard to local opinion in their decisions on the operation of local services and that it was undesirable that these opinions should always be expressed by officials. It was therefore agreed that the new Health Committee should contain fourteen representatives of the County District Group.

The Divisional Scheme in its final form provided for a Divisional Health Office with a clerical staff sufficient to carry out the routine clerical work of the Division, and in charge of a Divisional Medical Officer advised on nursing matters by a Divisional Nursing Officer. No Committees were set up except in the case of Watford Borough where the retiring Maternity and Child Welfare Committee was continued as an Advisory Committee on Child Welfare Services to which the Divisional Medical Officer should report on the operation of the services within the Borough.

Whenever possible the running of the established health services has been delegated to the Divisional Health Offices, but for certain services there was difficulty in doing this at once.

The cost of the day nursery service has led to its having very special attention from the Finance Committee. On several occasions the Health Committee, in an endeavour to cut down costs, reviewed the grounds on which children were to be admitted to the Day Nurseries.

The staffing of over 1,000 Nursery places in 20 establishments has been complicated. To a large extent we depend on our Nursery Trainees for staffing but, in order to have our Nurseries approved as training establishments, we have to give assurances that the girls who are taken for training are given a proper range of general and special education and the necessarily varied experience in different types of child care. This has meant a close link with the Education and the Children's Departments in arranging for Further Education and for the transfer of students between Day Nurseries, Nursery Schools, and Residential Nurseries. Complicated adjustments in staff could be handled only by one person, and this was best done by the Day Nursery Supervisor. For these reasons, it was not practicable at the outset to delegate the running of the Day Nurseries to the several Divisional Medical Officers. During the past few years they have been brought into the picture more and more, and it has now been arranged that apart from the staffing question which must remain a central responsibility, the Matron of the Day Nursery will look to the Divisional Medical Officer for day-to-day advice, and the County Medical Officer will look to the Divisional Medical Officer for ensuring that the Day Nurseries continue to run satisfactorily.

There has been, too, some difficulty in arranging the precise measure of delegation of Nursing Services. The County Nursing Officer has a direct responsibility to the County Medical Officer for their efficiency which she cannot discharge if the Divisional Medical Officer is given a fully delegated authority over the nursing staff working in his Division. The difficulties arising from the

situation, however, have been largely overcome by free discussion of nursing problems at our monthly Divisional Medical Officers' Conferences at which the County Nursing Officer is always present, by visits each month to individual Divisional Medical Officers by the County Nursing Officer at which local difficulties are discussed, and by regular Conferences of the Divisional Nursing Officers at which they are informed of the results of the County Nursing Officer's meeting with the County Medical Officer, the Divisional Medical Officers, the Chest Physicians, and other senior members of the staff who look to the nursing services for some reason.

It has been particularly difficult to devise some means of giving the Divisional Medical Officer a worthwhile interest in the work of the Midwives in his Division without at the same time interfering with the County Nursing Officer's responsibilities as Non-Medical Supervisor of Midwives. It has been necessary to call on her to delegate many of her supervisory duties to the Divisional Nursing Officers and yet continue to accept responsibility for the standard of the midwifery service in the County.

The situation was one which might well have been resented by the County Nursing Officer as placing an unfair load on her shoulders, but it was accepted and so far no serious difficulties have arisen. There have been minor difficulties in Watford and District, where domiciliary nursing is done from the Queen's Training Home. Although the cost of this Home and the responsibility for the home nursing in the district is borne by the County Council, the fact that the Home is an approved Queen's Training Home and that it has a Home Committee has obliged us to make rather special arrangements. The Divisional Medical Officer attends the meetings of the Home Committee, and deals with any problems referred to him by the Committee or by the Superintendent of the Home. The Superintendent is given considerable personal responsibility in appointing trainee staff, and in organizing the work of the Staff Nurses and of the pupils. The Divisional Medical Officer tacitly accepts the fact that the Superintendent is the one best qualified to supervise the work of the Home Nurses in the district, and the Divisional Nursing Officer's responsibility is theoretical rather than practical.

In the same district the domiciliary midwifery was delegated to the Hospital Board in order that our Maternity Home could remain in being as a Part II Training Home. The County Council pays a proportion of the salary of the Matron of the Maternity Home and the whole of the salaries of the Training Midwife and Staff Midwives. Here, too, the Divisional Medical Officer keeps in close touch with the Midwifery Services, and this is true also of the County Nursing Officer as non-Medical Supervisor of Midwives, but in practice there is little occasion for us to concern ourselves with the efficiency of the Service or of the individuals working in it.

The new Act brought about so many changes in the scope of the Mental Health Services that it was considered unwise to delegate this to divisional level until we had had an opportunity of becoming familiar with the operation of the scheme at Headquarters.

The Occupation Centre Service in the County too was being expanded when the new Act was introduced, and the problems of deciding which cases would be accepted for work at the Occupation Centres, finding buildings suitable for Centres, making the necessary arrangements for the transport of the children, and appointing the appropriate staff were obviously, in the first instance, best undertaken by a member of the central staff. Now that the demand has been reasonably well met, the Divisional Medical Officers have been asked to interest themselves in the work of the Centres so that, in time, the Centre Supervisor will be able to look to the Divisional Medical Officer for guidance and advice on all but matters of high policy.

Two Occupation Centres and six Day Nurseries were in the two Divisions in which there is no Divisional Medical Officer, and arrangements had to be made for the work of the Divisional Medical Officer to be done by the Head-

quarters staff. This, of course, meant more work but, at the same time, it has been found useful for the County Medical Officer and his Deputy who are preoccupied with administrative decisions to keep in touch with the actual operation of the services in the two Divisions in question.

It was also decided that almoning services could not be delegated since this, too, was a new development which should be studied and controlled centrally in the first instance. After about two years the demands for almoning services in the South West Division were such that a whole-time Almoner had to be allotted to this district and the Almoner in the South-West Division now virtually works as a member of the Divisional Health Office staff.

It had been intended that Almoners elsewhere in the County would gradually come to work from the Divisional Health Offices but in practice it has been found that the Almoners have been so monopolized by the Chest Physicians that it will probably be found advantageous to centre our almoning services on the Chest Clinic in each Division in future. There has been little demand or little opportunity for other forms of almoning and there is no good reason why an Almoner centred at a Chest Clinic should necessarily confine her duties to tuberculosis almoning.

Although these services have continued to be organized from Headquarters their operation and decisions affecting policy have been freely discussed at the regular Conferences of Divisional Medical Officers. It is necessary that this should be done, so that the Divisional Medical Officers would be aware of what is happening throughout their Divisions and that decisions affecting the centralized services would not conflict with anything that was happening locally. It is true to say, therefore, that the Divisional Medical Officers have been aware of and have paid a part in the development of the centralized services and during the past five years more and more responsibility in connection with these services has been placed upon them.

Co-ordination and Co-operation with other parts of the National Health Service.

Hospitals.

The Ministry's ban on officers being nominated by the Local Health Authority to serve on Regional Hospital Boards " save in exceptional circumstances " was unfortunate. It would have been helpful to have been aware of the discussions that were taking place at many of the Committees of the Regional Hospital Boards which serve this County.

One of the Divisional Medical Officers in this County was by virtue of his position as Medical Officer to an Isolation Hospital invited to serve on a Hospital Management Committee, and his intimate knowledge of hospital developments and plans in his Division was of value both to himself and to his colleagues at the Divisional Medical Officers' Conferences. In another instance, the Divisional Medical Officer has been elected a member of the Medical Advisory Committee of the Hospital Management Committee and, with a foot in both camps, he has been able to do a great deal to keep things running smoothly.

The liaison Committee at member and officer level which is now under discussion, even if found to be practicable, will not be a satisfactory alternative to exchange of views at officer level on projects which are under consideration by either the Boards or the Local Health Authorities.

When it was known that this County was going to be served by three Hospital Boards certain difficulties were predicted. In practice these difficulties have been rather worse than was anticipated. There is no need to enlarge on the complications of framing policy and trying to keep in step with the activities of three Hospital Boards, each of which may interpret the Ministry's Regional Hospital Board Circulars in a different way. When it is known that some development is in the offing it is, of course, possible to contact the appropriate

officers of the Board but, more often than not, one is dependent on the irregular receipt of Regional Hospital Board Circulars or on chance bits of information gleaned from colleagues.

General Practitioners.

Here one can be much more cheerful. The numerous medico-political meetings held to discuss the various Health Service Bills and the National Health Service Act in its final form led to many meetings with the General Practitioners in the County. The complications of the new Proposals were so great that it was difficult for anyone who was not in touch with Hospital, Consultant, Local Health Authority, and General Practitioners views and duties to get an idea of the projected new Service as a whole. The County Medical Officer was in a very fortunate position in this respect and was called upon by his medical colleagues on many occasions to explain the interaction of the proposed new services. The nomination (*ex officio*) of the County Medical Officer to the Local Medical Committee and Local Obstetric Committee reinforced these relationships with the General Practitioners, and the fact that there was no ban on the nomination of the County Medical Officer by the Local Medical Committee as a member of the Executive Council completed the picture. In this County the relations between the officers of the Local Health Authority and the General Practitioners are more effective and happier than ever before in my experience.

Specialists.

Despite the failure of the Act to forge any effective link between the Hospital and the Local Health Authority Services a great deal has, of course, been done. Many of the Consultants had been officers of the County Council working at our Hospitals before the Appointed Day and the Administrative Medical Officers of the Regional Hospital Boards were old friends from the Local Government Services. But for these old friendships and contacts our work would have been infinitely more difficult and less effective and one hopes that some means of re-uniting the two Services will be found before the present generation of administrators has been replaced by those with no common ties.

STEPS TAKEN TO INFORM GENERAL PRACTITIONERS ABOUT THE NEW SERVICES.

The complexities of the new Services are great and it is not surprising to find that many of those employed in them are often extremely vague about the rest of the service and, indeed, sometimes even about the particular branch in which they are working. The County Medical Officer has to have a working knowledge of all parts of the scheme and, as a consequence, he has become to the public, to the Committees, and—perhaps most useful of all—to the General Practitioners a source of information on many of the services which are not his direct responsibility. This was an unexpected development but it has proved to be an interesting and undoubtedly a most useful one.

For many years General Practitioners have been insistent that they should have a place on the various County Health Committees and when the constitution of the new Health Committee was being drafted it was arranged that four General Practitioners, nominated by the Local Medical Committee, should be invited to serve. These representatives have attended regularly but my impression is that they are now feeling that they derive little benefit and make little contribution to the work of the Committee. Personally, I find the contacts in the less official atmosphere of the Local Medical Committee much more useful, but I have no doubt that it was as a gesture of appreciation of the County Council's action in inviting these Practitioners to serve that I was in turn invited to serve on the Executive Committee of the local branch of the British Medical Association. In this capacity I have had many opportunities of inform-

ing General Practitioners about the operation of the County Services. One has been impressed by the interest the Practitioners have shown in the work of the officers of the Local Health Authorities but appalled at the extent to which General Practitioners are unaware of the qualifications and duties of members of my staff. This is, of course, a criticism of our Medical Schools and the Public Health Service—not of the General Practitioner.

Steps taken to inform the Public about the Service.

The idea of compiling a Handbook to explain the operation of the services in this County was, of course, considered soon after the Appointed Day but had to be deferred until several outstanding issues had been settled. Some of these issues are not yet satisfactorily settled and in the meantime it has become obvious that it is virtually impossible in a County served by three Regional Hospital Boards and covering two Ministry regions, in which a partial scheme of divisional administration is in force to produce a handbook of reasonable length which will give the correct answer and instruction for all services in all parts of the County. It may ultimately be necessary to do one for each Division but at present the scene is changing so rapidly that any handbook will inevitably be out of date before it is published.

Joint Use of Staff.

General Practitioners.

General Practitioners are employed on sessional payments in 80 Infant Welfare Centres sessions monthly and 42 Ante-natal Clinic sessions monthly in the County. For the past ten years it has been the declared policy of the County Council to employ whole-time medical staff in its Health Services. This policy has been brought into practice quietly as opportunity arose, but we have tried to avoid displacing General Practitioners merely for the sake of having a tidy staffing scheme. The encouragement in Circular 118 to use General Practitioners for staffing Local Health Authority Clinics was not allowed to affect the County Council's policy.

The idea of employing General Practitioners in Local Health Authority Clinics is theoretically attractive and was at one time strongly pressed by the Practitioners. In practice there are great difficulties in persuading a traditionally busy General Practitioner to arrive punctually and to remain until the advertised closing time of a session during which he may see very few people who, in his opinion, require medical advice or attention. The General Practitioner's existence depends on his skill in selecting quickly those who require attention from the mass of his patients. In Local Health Authority work the Medical Officer encourages people to come to see him and his skill lies in his ability to detect when medical advice is needed in advance of this being obvious. As soon as it is apparent that a case requires treatment he has to transfer it to someone else.

One unexpected result of the new Health Service is that though the demand for work in Local Health Authority Clinics has been increased from General Practitioners who were obliged to find additional sources of revenue I am now more often being urged not to appoint General Practitioners to Clinics. There are several obvious reasons for this. The General Practitioner working in a Local Health Authority Child Welfare Centre for example enjoys opportunities of attracting families to his Part IV List. No matter how ethically punctilious he may be, he will, if he is doing good work at the Clinic, impress the young mother attending there and it is natural that she should automatically turn to him in time of illness if she has not already chosen a general practitioner.

Before 1948, the Medical Officer at an Infant Welfare Centre or Ante-Natal Clinic had a certain latitude in observing the instruction that no treatment was to be given. Where one was satisfied that the mother was unlikely to be willing

or able to pay the fee for consulting her family doctor one could advise some simple remedy which she could buy at a chemist. This compromise is no longer possible. A mother can now consult her doctor without paying a fee but if she goes to a chemist to obtain some medicine advised by a Clinic Doctor she has to pay for it. The doctor at the Welfare Centre may be only too well aware that the mother will resent having to sit through a surgery queue in order to get her family doctor to give advice on a subject which might easily have been dealt with by the doctor at the Clinic but there is no alternative if she wants free medicine. He may even be aware that the mother has no intention of going to see her doctor. If our Infant Welfare Centres survive this loss of prestige it will be a reassuring tribute to the value of their preventive work.

Where a doctor in general practice in the locality is also acting as Medical Officer at the Welfare Centre the situation is much more or much less complicated. A proportion of the mothers attending the Centre will be on his general practitioner list. If he has a virtual monopoly of practice in the district he is tempted to turn the Infant Welfare Centre into an Infant Surgery Session. The alternative would be the absurd, Gilbertian, situation in which he would see the child as Clinic Doctor in the afternoon and refer it to himself as general practitioner for treatment the following morning. If the Medical Officer has not a monopoly of practice in the neighbourhood the situation becomes very difficult indeed. If he prescribes for his own patients at the Clinic it is understandably resented by the other practitioners in the town on the grounds that he is exploiting the situation to his own advantage, and they may even discourage the mothers on their Lists from seeing the Medical Officer at the Welfare Centre, and in time the Medical Officer's consultation sessions are limited to his own patients. If he is scrupulously careful and refers all patients belonging to other doctors to these doctors and, to avoid giving any of his patients any advantage, refers them to his own surgery, he will irritate the mothers, and may very well lose them from his List as patients. Some General Practitioners appear to be able to avoid these pitfalls but the situation must always be difficult.

Local Health Authority Staff and Hospital Service.

Our relationship with the Pædiatricians practising at the Hospitals in this County has always been good and, even before 1948, the desirability of finding some way of arranging a free interchange of staff between the Child Welfare Services and the Pædiatric Units in our Hospitals had been recognized and stressed. Soon after the Appointed Day a meeting of the Pædiatricians was convened in the hopes that it would be possible to organize a scheme on these lines but despite genuine goodwill and enthusiasm on both sides nothing was achieved. The Pædiatrician himself obviously cannot indefinitely change places with the Medical Officer working at a Welfare Centre. The House Surgeon at a Pædiatric Unit is occupied with the task of learning to treat the sick, and his term of office is at an end by the time he could, with profit to himself and to our services, take a spell of duty at the Infant Welfare Centre. One Assistant County Medical Officer for many years has, at his own expense, attended at the Great Ormond Street Out-Patients' Department on Saturday mornings. At another Hospital an Assistant County Medical Officer with twenty years' service in the County has been doing regular Ward Rounds in company with a Pædiatrician but, unfortunately, there is no place in the organization of a Pædiatric Unit in which she can be given a recognized appointment and real responsibility.

From all points of view it is very regrettable indeed that it has not been found possible to forge this link between the two Services. It would obviously have been useful to the Hospital if they could have called on a number of well-trained Officers from the Local Health Authority Services. These Officers, in their normal work in our Clinics, could have done much to relieve the load on the Hospital Out-Patients Departments. For our part such an arrangement would have done much to maintain the prestige and effectiveness of the medical work at our Welfare Centres.

An interesting experiment is being carried out at one of our Hospitals in which the Pædiatrician holds several County appointments as Medical Officer to Special Schools and in other ways is in close touch with the Public Health Services. He has noted that his work in the Hospital Out-Patients' Department is often abortive or needlessly complicated by the lack of an effective link with the child in its own Home. His suggestion that he should be allowed to call on our Health Visitors to give him information on the home background of his cases or to help the mother to carry out his instruction in the home is being eagerly followed up.

Use by Local Health Authority of Regional Hospital Board Staff.

The hospital authorities have been most helpful in making it possible to maintain the Specialist Clinics on which our Ophthalmic Service was based and, as far as the public is concerned, the Appointed Day made no change in the running of these Clinics. Again, the elaborate, complicated, but we believe effective, Child Guidance Service developed as an activity of the County Mental Hospital has been maintained, though three years of negotiation by Officers of the County Council and of the Regional Hospital Board—all anxious to achieve a settlement—has so far failed to arrive at an equitable formula for apportioning the costs of the Service.

Some of our Ante-natal Clinics were, before 1948, conducted by Obstetricians at our Hospitals and Maternity Units, who have since been given consultant status by the Hospital Boards. Thanks to the ready co-operation of the Boards, it has been possible to preserve this arrangement which continues to work satisfactorily, and prevents a duplication of services as between the Hospital and the Local Health Authority in the same town. I am hoping to extend this arrangement to other towns by merging the Local Health Authority Clinic with the Hospital Clinic. Most women who intend to be confined at home engage a doctor for the confinement. The doctor is under an obligation to give ante-natal care, and it is no longer justifiable in many instances to have a Medical Officer standing by at the Local Health Authority Ante-Natal Clinics. It can be argued, of course, that the Local Health Authority Clinics still have a duty to perform in teaching the mothers about their way of life during the ante-natal period and the preparation that should be made for the expected infant but, in practice, we find it very difficult to get mothers to come to Clinics except to see a doctor, and they are unwilling to listen to class instruction unless it is a means of passing the time while they wait to go into the doctor's consulting room. Where there is a Hospital Ante-natal Clinic in the town the obvious solution is to merge the Local Health Authority and the Hospital Clinics. When this is done our educational work can be extended to cover both the mothers to be confined at home and those who are to be confined in hospital and it is logical that this should be so because both parties are equally in need of this instruction. A proportion of the mothers who still come to our Clinics are those who have booked a midwife for a domiciliary confinement. I have no doubt that arrangements could be made for midwives to see their own cases at the Hospital Clinic. The Midwives should welcome the opportunity of being associated with the Hospital Ante-natal Clinic where they can keep in touch with the latest methods and where, if necessary, they can get a specialist's opinion on the case which would be of great value to the midwife when later she came to be responsible for the confinement at home.

In some areas a large proportion of the domiciliary midwifery is in the hands of one doctor who finds it convenient to discharge his responsibility for ante-natal care by convening what amounts to a private Ante-natal Clinic at his Surgery at regular intervals. In some instances our Midwives attend these Surgery sessions. No doubt the doctor gets a certain amount of free help in the organization of the session but this is more than offset by the value to the midwives of seeing their cases regularly in company with the doctor who will be called in an emergency if anything goes wrong during the confinement.

A rather special problem arose at one place on the borders of the County where mothers who were to be confined in hospital had to look to a hospital some miles over the County boundary. The Obstetrician in charge of the Unit disliked the arrangement for several reasons. Cases were accepted on the grounds of social need but the genuineness of the need had to be assessed by an Almoner with no knowledge of the locality from which the patient came and with no means of checking the accuracy of the story given them by the applicant. To get ante-natal care a patient was obliged either to attend the Hospital Out-Patient Department or go to the Local Authority's Ante-natal Clinic in her home town. Both alternatives were unsatisfactory. Many mothers were put to the inconvenience of making the journey to hospital for intercurrent ante-natal examinations though there was no good reason why these examinations should be made at a hospital. If, on the other hand, the mother had decided to attend the local Clinic she was seen by staff who had no access to the hospital records. The third—and possibly strongest—objection was a very valid one but one which I am sorry to say applies in several districts in this County where the question of distance does not arise. The Obstetrician noted that when the mother came to leave the Hospital she went back to the care of a Midwife who had no knowledge of the progress of the confinement or of the complications that had arisen ; or perhaps to a Health Visitor who was given no information about the infant's condition during the period of its stay in hospital. These difficulties were quickly disposed of when we agreed :—

(1) We were to be consulted where there was any doubt about the validity of the applicant's claim to be admitted to hospital on social grounds.

(2) The Health Visitor was to be notified as soon as a mother from her district booked at the hospital so that the Health Visitor could make touch with the mother and get to know her during the ante-natal period. Health Visitors were also to be encouraged to visit the mothers in the Maternity Hospital not only to maintain the friendly contact made during the ante-natal period but also to keep themselves informed of the progress of the mother and her infant.

(3) Apart from the few ante-natal visits which had necessarily to be made at the Hospital the patients were to be given the option of attending the Local Health Authority's Clinic. A system of interchange of records between the Hospital and our Clinic was easily arranged.

(4) The Local Health Authority was to be notified of the impending discharge from hospital of the mother and infant. Special notes for the guidance of the Midwife or the Health Visitor were to be given in any case where the mother or infant required special attention. In the absence of any such notes it could be assumed that the case was normal in every respect.

The Medical Officer, the Midwives, and the Health Visitors working in the local Ante-natal Clinics and Welfare Centres were invited to visit the Maternity Unit partly in order to familiarize themselves with the technique applied in the Hospital but also so that they might be able to give mothers in the district the very desirable impression that they and the hospital authorities were working in complete harmony. The visit concluded with a standing invitation to any members of the staff to come at any time to the Hospital either to see the work or the patients. Some time later a rather similar situation arose in another part of the County where the development of two L.C.C. Housing Estates had thrown the maternity provision badly out of balance and arrangements had to be made for hospital cases to be confined at a Maternity Unit outside the County. Staff at the Local Health Authority Ante-natal Clinics in the areas served by this Hospital has been reinforced by a Midwifery Sister from the Hospital so that the intercurrent visits can be arranged without obliging the mother to travel to the hospital.

Training of Pupil Midwives.

In Watford and District the maternity services are run on behalf of the Local Health Authority by the Hospital Management Committee. This was done in order that they might retain the Pupil Midwives Training School which was established in that neighbourhood. There has been considerable housing development in this district and the domiciliary midwifery scheme has been extended to meet this development. There are now three Midwives' Homes in the district staffed and run by the Management Committee within estimates which are approved and carried on the Budget of the Health Committee. The demand for Part II Midwifery Training facilities has, however, far exceeded the not inconsiderable supply made available in this way and, in the meantime, two more of the Maternity Units in the County have become Part II Training Schools. It was neither possible nor desirable to delegate midwifery services to these Hospitals since, apart from the towns of the size of Watford, our midwifery and district nursing is very often so closely combined that it is impossible to separate the two Services. We had, therefore, to find some other way of providing this training material. Only a relatively small number of our Midwives are handling over a reasonable period the number of cases required by a Pupil Midwife to complete her domiciliary training, but most of this number have now been approved by us and the Hospital Maternity Training Staff and have been asked to take Pupils. The limited value of the scheme in offering extended training facilities has no doubt justified the time and effort that has been put into it by Officers of both the Local Health Authority and the Hospital Management Committees but it has produced several rather unexpected complications. For example, the Pupil should live with the Midwife to whom she is attached during her period of training but a Midwife living by herself in a small house does not always welcome company. A more serious difficulty is the fact that most of our Midwives really enjoy their work. They have watched with dismay a larger and larger proportion of cases drifting to the Hospitals for confinement and they intensely dislike standing by while a Pupil deals with the few domiciliary confinements that remain. One frequently hears the argument that the more the Midwife sacrifices herself to train Pupils the bigger will be the staffs in the Hospital Maternity Departments and the higher the proportion of hospital confinements. We have lost more than one good Midwife from a training district because she felt that she was not getting the practical work which she wanted, and we are now obliged to limit the placing of Pupils to those Midwives who freely accept them. The arrangement too has its financial complications. The Hospital Boards are only too willing to meet any of the obvious expenses but the Local Health Authority has undoubtedly borne a hidden cost in having to provide in some instances bigger houses which could house both the staff Midwife and the Pupils and in other places to retain Homes which are, of course, much more expensive to run but essential where pupils have to be accommodated in districts, where there would otherwise be a case for doing away with the Home and providing the individual midwives with houses or flats.

Voluntary Organizations.

County Nursing Association.

For three years after the Appointed Day the County Nursing Association and some of the remaining district Nursing Associations retained an interest in the wellbeing of the nurses and the Nursing Services though the Local Health Authority took over full responsibility for finance, organization, and discipline. The County Nursing Association has now given way to the County Nursing Trust, on which the County Health Committee and its Officers are represented. The Trust, in turn, has been invited to appoint two members to the Health Committee.

In recent reports I have paid tribute to the work of the County Nursing Association and referred to some of the more obvious gaps in the service which

will be left by its passing but there have been minor unexpected difficulties which have only now become apparent. For example, certain of our nursing staff are entitled to a house, furnished or unfurnished, as part of their emoluments. The problem of clearing up a house after the nurse has left and preparing it for the incoming nurse is a very real one in a department which has no staff to deal with this sort of thing and only too often the brunt falls on the administrative nursing staff. In matters of this kind, one misses the friendly and helpful contacts which were a feature of working with the several district nursing associations.

I have no doubt, however, that my prediction that the complicated organization and the running of the unified nursing service would be incompatible with any measure of delegation to a voluntary organization was a sound one.

British Red Cross Society and St. John Ambulance Brigade.

The County Medical Officer and the County Nursing Officer serve as members of the Executive Committee of the British Red Cross Society and have invariably found the Society willing to help the statutory services in any way possible, though here, as elsewhere, it is found that the number of members who are able, as opposed to those who are willing, to give voluntary services in the day-time is becoming increasingly limited.

The special work of the British Red Cross Society in connection with our scheme for Gas and Air Analgesia has been referred to in several of my recent Annual Reports.

The two organizations, collectively or independently, give help to the Local Health Authority in the following way :—

(1) *Medical Loan Depots.*—36 Depots are maintained throughout the County. Charges are made in accordance with Circular 100/48. The moneys collected are applied to the replacement of articles on a scale approved by the Health Committee. Major items are obtained where possible through the County Purchasing Officer. This Medical Loan Service is supplemented by the small stock of nursing equipment held by each District Nurse. The supply of unusual types of equipment or the loan of equipment to infective cases is handled by the County Health Department.

(2) *Occupational Therapy.*—In the early days of the new Service the British Red Cross Society offered to continue, with the aid of a small grant, the diversional therapy scheme for domiciliary tuberculous patients which had previously been organized from our Sanatorium. The need for occupational therapy has grown steadily in recent years and the scheme is being revised to keep pace with the demand.

(3) *Library.*—For many years the joint organization of the British Red Cross Society and the St. John Ambulance Brigade have run a postal scheme for supplying books to home-bound cases of tuberculosis. In 1949 they offered to develop the scheme on more formal lines as part of the Chest Clinic Services. The scheme was organized to meet the estimated demands in the south-west and south of the County. It has been found in practice that the demand varies widely and the scheme is again being modified to encourage patients suffering from open tuberculosis to use the T.B. Library rather than the Public Libraries.

Voluntary Workers in Infant Welfare Centres.

Apart from Watford and Oxhey all our Infant Welfare Centres in this County have an associated group of voluntary welfare workers. In some they are organized as a Committee and appoint a rota of workers. In others a small group of devoted ladies turns up regularly to perform their allotted tasks. When a new Welfare Centre is to be opened our first step is to collect the nucleus of a Voluntary Committee. This Committee is then given an initial loan of £10 which is spent on the purchase of Welfare foods for sale at the Centre. Thereafter the voluntary workers take full responsibility for ordering, buying, and

selling these foods. This arrangement has worked well and has resulted in the very considerable saving in administrative costs to our Service. The voluntary workers also handle the Ministry of Food supplies of Welfare foods. This arrangement is a great convenience to mothers, particularly in the rural areas, and undoubtedly does much to encourage them to use these valuable supplements.

Voluntary Workers in Day Nurseries and Home Help Schemes.

These are both optional services for which charges must be made ; they are also costly. For these reasons it has been necessary to exercise a very strict control over them and the scope for interesting Voluntary Committee work has been correspondingly curtailed. Nevertheless, in several areas, the Committees which did such good work in the early days of the services have remained in being and continued to do useful work.

In the Day Nurseries, for example, the Committee can do a great deal to help the Matron in her more social, but none the less valuable, work, e.g. Parent Meetings and Fathercraft Classes. Some Home Help Committees are active in organizing social activities amongst the Helps. This undoubtedly serves to inculcate an *esprit de corps* in the Home Help team and raises the standard of the service in the locality.

National Association of Parents of Backward Children.

This is a new Organization which has recently done a great deal to interest the public in the problems of the parent of a backward child. Their work has done much to condition members of Committee and public generally to accept the idea of schemes for the welfare of these unfortunate children. In several instances a group of the Association has been organized in the towns in which there is an Occupation Centre. These local groups are functioning very much in the same way as Parent Teacher Groups in our schools. They have done much to help and encourage the staff and provide amenities for the children.

SECTION 22—CARE OF EXPECTANT AND NURSING MOTHERS.

Ante-natal Clinics.

On the 31st December, 1947

(1) Population . . .	497,389
(2) Ante-natal Clinic Sessions	1,003
(3) Midwives' Clinic Sessions .	—
(4) No. of patients . .	3,854
(5) Total attendances . .	14,276

These figures do not include the services provided in the Borough of Watford which was its own Maternity and Child Welfare Authority until 1948. If we exclude Watford Borough and the L.C.C. Housing Estate at Oxhey, in order to get comparable figures, the picture on 31st December, 1952, was as follows :—

(1) Population . . .	545,660
(2) Ante-natal Clinic Sessions	689
(3) Midwives' Clinic Sessions .	118
(4) No. of patients . .	1,363
(5) Total attendances . .	5,199

The 1952 figures for Watford Borough are :—

(1) Population . . .	73,200
(2) Ante-natal Clinic Sessions	154
(3) Midwives' Clinic Sessions .	—
(4) No. of patients . .	516
(5) Total attendances . .	2,099

and for the L.C.C. Estate at Oxhey :—

(1) Population . . .	14,840
(2) Ante-natal Clinic Sessions .	68
(3) Midwives' Clinic Sessions .	—
(4) No. of Patients . .	633
(5) Total attendances . .	2,278

The drop in the attendances at our Ante-natal Clinics is no doubt a reflection of the increase in the number of hospital confinements and the fact that the general practitioner booking a domiciliary obstetric case is obliged to give ante-natal and post-natal care. Mothers are unwilling to attend both the General Practitioner's surgery and the Local Health Authority Ante-natal Clinics. These two factors have been offset, to some extent, in Watford and Oxhey because there is a shortage of maternity beds compared with the rest of the County and there is also a domiciliary midwifery training scheme which has made necessary a close working arrangement between the General Practitioner and the midwives doing domiciliary work in this area.

It was noted earlier in this report that some of our Ante-natal Clinics are run by medical officers holding obstetric appointments on the staff of the Regional Hospital Board. In one instance it was agreed that the Obstetrician in charge of the Obsteric Department in the local hospital should continue to run the Local Health Authority clinic on the understanding that he should be at liberty to see at the Clinic a proportion of hospital cases. In another instance the reverse arrangement has been agreed upon. Here too the Medical Officer of the Local Health Authority Ante-natal Clinic is in charge of the Obstetric Unit in the hospital in the town. The number of mothers attending the Local Health Authority Clinic has decreased so considerably that the Medical Officer suggested that he should cut his visits to the Clinic to one per month on the understanding that the domiciliary midwives working in the town were always at liberty to refer their cases to him at the Hospital Ante-natal Clinics. Reference has already been made to instances in which the Local Health Authority Clinics provide Ante-natal care for patients booked for confinement in hospitals outside the County.

It has been made known to the General Practitioners that we are sympathetic to the idea of our midwives attending at a doctor's surgery when he is giving Ante-natal care to mothers booked for domiciliary confinement. There are obvious difficulties in this arrangement but none of these are insuperable. One Practitioner who took up this idea early in 1949 found it most helpful to himself and to his patients but he expressed doubt as to whether it was fair to a midwife to make this further demand on her time because it was not easy to arrange his Ante-natal sessions to fit conveniently with her other duties. He spoke too of his difficulty of deciding in his own mind the precise dividing line between the legitimate use and the exploitation of the Local Health Authority midwife in his surgery practice. This particular surgery clinic has been discontinued but if we have faith in the value of teaching given at Ante-natal clinics and the importance of the midwife seeing cases in company with the General Practitioner Obstetrician we clearly must find some way of ensuring that the Health Visitor and the midwife should see Ante-natal cases at Practitioners' surgeries or that Practitioners should see their patients at a Local Health Authority Clinic at which these Officers are present. It would be difficult to give effect to either of these ideas in most places. The present domiciliary maternity scheme was introduced in an attempt to overcome some of the criticisms of our pre-1948 Ante-natal Clinic service. The new scheme has certainly broken up the old but one doubts whether it is an improvement. If it is not there is clearly a case for modifying the maternity medical service to preserve the best of both the old and the new schemes.

It should surely be possible to devise some system of Ante-natal Clinics organized by the Local Health Authority and staffed by Obstetricians associated with Local Maternity Units and Local Health Authority Midwives and Health Visitors at which Ante-natal care and education could be given to patients booked by General Practitioner Obstetricians. It would, of course, be necessary to ensure that there was an interchange of records between the Clinic and the General Practitioner Obstetrician but this was done successfully in many instances in the old days. It might be possible to insist in a new scheme that the General Practitioner Obstetrician should at appropriate intervals during

the ante-natal period see the patient in consultation with the medical officer of the Clinic.

Post-Natal Clinics.

Apart from Watford Borough and the Oxhey L.C.C. Estate the number of women post-natally examined at our clinics was 482 in 1947 and 368 in 1952. When related to the number of births occurring in these two years, we find that in 1947 16.5 per cent of mothers had a post-natal examination, and in 1952 16·8 per cent. The full value of post-natal examinations as part of our maternity services was not appreciated by mothers before the change-over in 1948. Under the domiciliary maternity scheme the General Practitioner must offer and endeavour to arrange a post-natal examination for each of his cases and this, of course, affects the number who can be expected to attend a Local Health Authority Clinic. The Executive Council has no record of the post-natal examinations done by the General Practitioners, but it is known that many women do not turn up for the final examination.

Blood Testing.

The instructions given to Medical Officers working at Local Health Authority Clinics on collection of blood specimens still stand though no statistics are kept of the number of specimens sent. The General Practitioners in the County have been circularized with information as to how to get blood specimens examined but, apart from a direct inquiry to the various laboratories which may be used, there is no way of finding out to what extent this information has been acted upon.

Unmarried Mothers.

The County Almoners continue to work in close association with the Moral Welfare Workers of the Diocesan Association for the care of the unmarried mothers. Usually a young girl having her first illegitimate child is passed to the care of the Diocesan Workers and arrangements are made for her to be maintained in one of the homes provided by that body. Ante-natal and post-natal care for these cases is arranged by the home concerned. The question of ante-natal and post-natal care by the Local Health Authorities Services seldom arises even in the case of the unmarried mother who is not sent to the Diocesan Homes since it is usually impracticable for her to be confined at home. Arrangements are accordingly made for her to go into a Maternity Hospital which assumes responsibility for ante-natal and post-natal care. In many cases our Almoners are able to arrange for these girls to spend the later part of their pregnancy working in the Maternity Hostel in which they will ultimately be confined.

Maternity Outfits.

Before 1947 there were few requests for help with equipment and dressings for a confinement but the Local Health Authority were obliged to offer Maternity Outfits as part of their Section 22 Services and the demand is now steady. In 1952 there were 3,368 Domiciliary confinements including those in Maternity Nursing Homes and 3,216 maternity outfits were distributed. The work involved in ordering and distributing this number of maternity outfits is considerable but it is probably worthwhile because it should obviate the temptation to the patient to try to "make do" during her confinement with unsatisfactory materials or to ask her Doctor to supply large quantities of dressing material for use during the puerperium.

Mothercraft Training in Ante-natal period.

This work is usually regarded as one of the duties of the Health Visitor but these Officers are in short supply and it is therefore necessary to consider

which of their duties can be undertaken by other members of the staff. Many of our domiciliary midwives are not fully employed because there is a physical limit to the area for which a midwife can be made responsible and we accordingly look to the domiciliary midwife in some districts to educate her cases during the ante-natal period. A proportion of our midwives are qualified Health Visitors but even where this is not so I doubt whether we would be justified in laying on a duplicate series of visits by the midwife for clinical care and by the Health Visitor for training. The good midwife probably has had as much training and experience as is necessary to give a primipara the instruction she can digest. The multiparous mother will have already had her instruction when attending the Welfare Centre with her first child. Where ante-natal clinics with a doctor and midwife in attendance are still in being it is, of course, possible for a Health Visitor to give formal group instruction in Mothercraft.

As I have noted elsewhere it is often assumed that the Infant Welfare Centre offers the ideal opportunity for the Health Visitor to do mothercraft teaching in a big way but in my experience this is not so. The Health Visitor is more usefully employed seeing her babies and giving advice to the individual mothers over the weighing scales or in the Health Visitor's room. If the Welfare Centre has a " Toddlers room " and an abundance of voluntary workers it may be possible to get a small group of mothers together for a talk, but even here it is difficult to talk convincingly about the abstractions of Health education though it may be possible to do practical demonstrations of various kinds. We are finding much better results from organizing Mothers' Clubs at which the mothers meet together without their infants at an evening or late afternoon session, sometimes with the father, sometimes without. At these clubs the mothers indulge in a free discussion of their problems under the guidance of a health visitor, or they may listen to lectures by experts on the subjects in which they are particularly interested.

Child Welfare.

The Infant Welfare Centre is still the most obvious feature of our Child Welfare Services. The fact that the introduction of the National Health Service has had very little effect on our Infant Welfare Centres is a tribute to the use that has been made of them. They have obviously been used as part of the preventive service and not as a casual way of obtaining free medical advice. In 1947 the population of 497,389 (excluding Watford Borough) was served by 93 Infant Welfare Centres which met 2,890 times. In 1952, the population of 633,700 (including Watford Borough), the figures were 114 Infant Welfare Centres meeting 4,112 times.

The Table which follows shows the extent to which the Centres have been used during the past five years.

TABLE 1.

	No. of Centres	Sessions Held	Doctors' Attendances	No of Children who Attended	Children's Attendances	
					Total	Average per Session
1948 (Watford Borough included) from 5.7.48.	104	3,148	2,385	21,465	145,018	46
1949 . .	109	3,648	2,758	20,589	160,480	44
1950 . .	109	3,820	2,755	21,719	155,475	41
1951 . .	112	3,946	2,879	23,287	158,902	41
1952 . .	114	4,112	2,996	24,202	169,588	41

There is a weekly toddlers centre in Watford. There are no specialist clinics and no clinics held by General Practitioners in their own premises, though an arrangement of this kind is under discussion at present.

Domiciliary Visiting.

The Health Visitors are still under instruction to do domiciliary visiting on our schedule of quarterly visits to children under one year and a six-monthly visit to those from one to five years. The shortage of Health Visitors and the continued popularity of Infant Welfare Centres have tempted the Health Visitor to neglect home visiting of those who attend regularly at the centres. This development is frowned on. Without home visiting the Health Visitor ceases to have true knowledge of the mothers and infants and ceases to enjoy the unique knowledge of the family unit which is one of our strongest justifications for maintaining the ubiquitous Health Visiting Service in the face of the increasing number of specialist social workers who encroach on one or other aspect of her work.

Premature Infants.

Quite elaborate arrangements for the special care of the premature infants were made in the early 1940s, and have been reviewed from time to time since but they are seldom called upon to function. The majority of premature infants are born in hospital ; and our midwives seem quite happy to deal with those born at home with the resources which they already command. The number of premature babies born alive during 1952 was 607. Though it is contrary to medical ethics it may be good sense to ask whether there comes a point at which the struggle to save the premature infant is biologically unsound and should not be over elaborated particularly if it demands hospital resources which might more usefully be employed otherwise.

Supplies of Dried Milk.

In Watford Borough and Oxhey L.C.C. Estate the supply of these foods is undertaken by paid staff because it has not been found possible to get voluntary workers. Elsewhere, as already noted, the voluntary workers at our Infant Welfare Centres have accepted responsibility for ordering and selling proprietary foodstuffs together with the distribution of the welfare foods supplied by the Ministry of Food. The work involved is considerable and our gratitude is due to these workers whose efforts affect a considerable saving to the rates and add to the value of the welfare centre services. No doubt many mothers who in the first instance come to the Welfare Centre to take advantage of this facility are persuaded to enter into the full fellowship of the Infant Welfare Centre activities.

An approach was made recently to the local Pharmaceutical Committee to consider the possibility of introducing a " chemist chit " system to cover the supply of proprietary foods and medicaments but this was found to be impracticable.

Reference has been made earlier to the difficulties which arise from the fact that the Medical Officer of an Infant Welfare Centre cannot issue a prescription under the National Health Service Act. There are circumstances in which a mother cannot be expected to go to her Doctor for a prescription and most of our Welfare Centres carry a small stock of medicaments which can be used by the Medical Officer in the course of her work, or supplied in small quantities to the mothers.

Dental Care.

In 1947 we treated 673 mothers and 620 children under five. For 1952 the numbers were 63 mothers and 658 children under five. The story of the decline of preventive dentistry is too well known to need repetition. As will

be seen from the foregoing figures the County Dental staff have kept pace with the demand for treatment for children under five but the treatment of the ante-natal mother has necessarily been allowed to lapse to a large extent. With the limited dental staff it is necessary to employ our staff in the first instance in an attempt to save the permanent teeth of the school child. Any remaining staff time is used for the " toddler " as it was felt that the ante-natal mother could more easily obtain attention under the general dental service.

Other Provisions.

Many of my reports in recent years have tried to show that the Day Nursery Service, as it is now regulated in this County, makes a very valuable contribution to positive health of our child population. These arguments will not be repeated here, but it would be wrong to conclude a review of what has been done under Section 22 of this Act without making a reference to the value of the Day Nurseries in their necessarily limited sphere of influence. A visit to a Day Nursery will quickly convince anyone of their value in safeguarding the health of the young child and educating the parents. It is a great pity that some modification of the Day Nursery idea cannot be devised in a form which retains its value but avoids the objections of cost and limited availability and the temptations to abuse, which are a feature of our present service. One hopes that the country will in time turn to a more normal way of life, and that the necessity for placing children whole-time in a Day Nursery will disappear. It may then be possible to give effect to the type of Day Nursery envisaged in our Proposals in 1947.

SECTION 23—DOMICILIARY MIDWIFERY.

Our arrangements are still based on those introduced in 1936. Our proposals stated our intention to develop a full-time midwifery service, if necessary by making the midwives more mobile and giving them a bigger district to look after. In practice little has been done. There were 16 full-time midwives in 1947, and the number remains unchanged in 1952. There has been no change in my opinion that a midwife should be fully employed if she is to remain efficient. The reason why little has been done to review the midwives districts is two-fold.

(*a*) the increase in hospital midwifery has made it increasingly difficult to find sufficient work for whole-time midwives in an area of a reasonable size.

(*b*) The difficulty of finding and keeping nurses and midwives is increasing. Nurses, in common with the rest of the community, want nowadays to lead a reasonable life. The nurse who is interested only in her work can remain in hospital and do concentrated midwifery or skilled nursing. If she elects to go into district nursing or district midwifery it is probably because she wishes to live in a more normal community and have a home and home life of her own. In our bigger towns domiciliary midwifery is the preserve of training schools and the midwives for the most part live in a Nurses' Home. In the rural areas we can't offer enough midwifery for a whole-time appointment. In the rural area, too, there is a further factor—the decline in interesting home nursing consequent on the more widely available and more freely used hospital service. As a result it is more difficult to find a nursing district of reasonable size and with the right balance of midwifery and interesting home nursing to keep a whole-time midwife and a whole-time home nurse happily employed. It is the best staff who most quickly become restive if they are not kept reasonably busy and this fact, and the absolute shortage of nurses, has obliged us to jettison our theories that the efficient midwife must have an agreed minimum number of cases per annum, and to retain areas which give a reasonable balance of midwifery and home nursing to one nursing officer.

Supervision.

The County Nursing Officer is also the non-medical supervisor of midwives. In the divisions she necessarily delegates some of her duties to the Divisional Nursing Officer, but since she remains ultimately responsible for this work she retains the right to decide the measure of delegation, and the right to deal directly with the midwives and to be directly accessible to them. There are obvious difficulties in reconciling this arrangement with the scheme of divisional administration but no real difficulties have been found in practice.

Technically the County Nursing Officer has still a responsibility for midwives working in Regional Hospital Board Maternity Units. It is true she is absolved of this responsibility if the unit is in charge of a resident Medical Officer but it is not always easy to decide whether this in fact is so. In practice she has been advised not to concern herself with midwifery in hospital units, except by invitation, or in the course of inquiries into a maternal or infant death or of outbreaks of infectious disease. In their supervision of the nursing homes in the County the County Nursing Officer and the Divisional Nursing Officers have ample opportunities of supervising the work of the private midwives in these homes. Apart from maternity homes the private midwife has practically disappeared from the County and supervision of the monthly nurse employed privately under medical supervision is not required.

Analgesia.

All of the midwives employed by the County Health Committee are trained in the use of gas and air analgesia. All but two of the nursing districts have at least one gas and air set and the two exceptions share. In all 73 sets are in use. The C.M. attachment is fitted to 47 of these sets, and it is known that several of the gas and air sets in use in the hospitals in this County also have the C.M. attachment fitted. The gas and air figures for the year 1952 were

Use of Gas and Air Apparatus in Domiciliary Practice.

	Confinements.			
	No. attended by :		*No. in which Gas and Air given.*	
No. of sets. available.	*Midwives.*	*Maternity Nurses.*	*Midwives.*	*Maternity Nurses.*
73	2,087	712	1,693 (81·1%)	583 (81·9%)

From replies received from 84 domiciliary midwives it is found that 65 commonly used pethidine, and 19 do not. Entries relating to the use of pethidine are inspected by supervisors when the midwifery records are being examined. Midwives are instructed to see that no surplus pethidine is left with the mother after the confinement is concluded.

Ante-natal Supervision.

Several of the ante-natal clinics in which there is no longer a need for a Medical Officer have been retained as midwives clinics, but as shown there has been a decline in the attendances at our clinics apart from Watford and district where the ante-natal clinics are associated with the domiciliary midwifery training scheme and still continue to be busy. It is difficult to know how far ante-natal supervision by midwives is being satisfactorily done, or indeed how necessary it is. The General Practitioner Obstetrician has a defined minimal responsibility in this connection. Many of them, of course, give a great deal more than this minimum but the extent to which this is true is not on record.

Some midwives have tried to continue to give ante-natal care as they did in the past. This, of course, is wasteful if the General Practitioner is already doing all that is necessary, but one can't blame the conscientious midwife if she insists on doing ante-natal supervision for herself in the absence of any precise information from the doctor as to what has been done and what has been

found. One has not recently heard so much about midwives being called upon to deliver patients without knowing whether ante-natal care has been given by the doctor but surely there is a need for consultation and planning between those who organize the maternity medical services and the Central Midwives Board to ensure that the patient does not fall between two stools, and that the midwife obtains all the requisite information about the patient's ante-natal care. Earlier in this report suggestions have been made as to how this could be done.

Selection of Cases.

This County is well supplied with maternity beds, with the exception of the south-west where the influx of the population has placed a further strain on a long-standing shortage. The institutional confinement rate in 1952 was 76 per cent for the County, apart from the south-west, in which it was 69 per cent. In Watford Borough and Oxhey L.C.C. Estate there is screening of patients when they first apply at the hospital for a bed. This screening is done by midwives who are anxious to conserve beds in the hospital and even more anxious to retain a sufficient number of domiciliary cases for their Pupil Midwife Training Scheme. Elsewhere in the County, one gets the impression, screening is practised only in so far as it is necessary to control applications in excess of the number of beds available and it is unusual to hear of cases which should have been admitted to a maternity hospital being refused. In two hospital management areas the Divisional Medical Officer has now been asked to co-operate with the hospital authorities in the selection of patients but so far the ultimate number of patients has been determined by the number of beds or the number of staff. There have been no examples of maternity units failing to book to capacity and restricting admissions to cases in which this was medically or socially necessary. It can, of course, be argued that it would be wrong to keep beds empty and that once the priorities have been satisfied beds should be allocated to women who prefer to be confined in hospital though there is no good reason why they should not be confined at home.

Refresher Courses for Midwives.

Four of the County midwives attended refresher courses during the year. It has been found that if this number is sent each year the staff can be kept up to date with their midwifery practice. The constant changes of staff means that a high proportion of midwives have not been with us for many years but there is also a proportion of senior midwives who do not welcome the idea of the refresher course and would derive little benefit from one.

SECTION 24—HEALTH VISITING.

Early in 1940, a start was made in building up a team of whole-time Health Visitors in contrast to the system of employing all-purpose nurses which had previously been in force. At the end of 1947 there were 34 whole-time Health Visitors (the number included two T.B. Visitors). In the County's Proposals it was stated that it was intended to develop this system to an ultimate ratio of one Health Visitor per 5,000 population. This would call for 120 Health Visitors at the present time. In fact there is the equivalent of $57\frac{1}{2}$ only and in addition 7 whole-time T.B. Visitors, a total of $64\frac{1}{2}$. Our failure to reach our target is attributable to several factors. Our establishment of Health Visitors is not based on a population ratio. In each case we have waited until the need was apparent before making an appointment. Demand varies considerably with locality and there are many areas with populations in excess of 5,000 which are adequately served by one Health Visitor. The ratio varies throughout the County from one to five thousand in Hemel Hempstead to one to eight thousand in East Barnet. A more important factor, however, is the fact that it has been quite impossible to recruit a sufficient number of Health Visitors. Hertfordshire has probably had more than its fair share of those available,

thanks to the scholarship scheme which has been running for many years in this County, and to the fact that this County is an attractive one to work in and has a long standing reputation as a " good nursing County ".

The situation has been saved to a considerable extent by the fact that for many years past we have encouraged candidates for training as district nurses to take the combined course of training for district nursing and health visiting. Many of those who completed this course found both types of work attractive. Many of the " all-purpose " nursing districts are still in existence in the County and it has been possible to offer applicants for nursing work a choice of appointments with nearly every possible permutation and combination of Health Authority Nursing.

The Committee were advised to appoint whole-time health visitors in the first instance because it was found that the all-purpose nurse often had a primary interest in midwifery or district nursing and no training or experience in health visiting. If her district was understaffed, or the nurse hard pressed, the health visiting went by the board. It is difficult to find in the same person equal enthusiasm for the curative work of the district nurse and the preventive approach of the Health Visitor. In the same way the average general practitioner, whose interest it is to cure the sick, is inclined to regard the work of the Assistant County Medical Officer as a waste of time. There are, too, very serious administrative difficulties in organizing the school health service if the Health Visitor and School Nurse is also the midwife or the district nurse with a morning round of visiting to complete.

On the other hand those of us who are survivors of the days when the Assistant Medical Officer had clinical responsibilities will remember how much better our preaching was accepted by those who benefited by our ministrations. This is no less true in health visiting. If one can find a nurse with an interest in health visiting and ability in district nursing and midwifery she has very special opportunities for doing good work in all three capacities. The number of these nurses is limited, and the idea can probably never be the basis of a nursing service, but we are fortunate in having several of this type in Hertfordshire. In all, 52 of our nursing staff are doing health visiting in addition to duties as district nurse or district nurse/midwife. Of this number 15 have a health visitors' certificate.

An unusual arrangement is to be found in the county. Off-duty time for the district nurse/midwife must be arranged during the working week and it is not always easy to make a standing arrangement for a neighbouring nurse to take over her duties. Many of our health visitors are well-qualified midwives and in some areas the health visitor has agreed to act as a relief midwife. This is a very happy arrangement administratively and it entitles the health visitor to certain advantages, e.g. longer holidays and accommodation provided by the Authority at a preferential rent.

Efforts have been made to discover some way of ensuring that the health visiting service will be used to reinforce the work of the general practitioners. The field study by the London School of Hygiene which is being carried out in the south-west division of this County is paying particular attention to this point and any workable scheme which results from this study will certainly be given a trial. The first step, undoubtedly, is to make the general practitioner more generally aware of the existence, the qualifications, the duties, and the capabilities of the health visitor.

Co-operation with Hospital Services.

Early in 1948 it was made known to the hospitals that our health visitors would co-operate in every way possible to forge a link between the patient in hospital and his home background. Reference has been made to some of our efforts in this direction but there have been few requests for help. The late Professor Ryle, of Oxford, adduced convincing arguments and evidence to show that the mere treatment of the patient in hospital fell far short of the ideal

attainable. His views were widely accepted and one would have thought that the National Health Service would have led to progress in this direction.

Training.

For many years this County has awarded health visitors scholarships to suitable applicants who were prepared to give two years' service in the County after taking the higher qualification. The Health Committee have authority to award up to 12 scholarships in any one year but owing to shortage of suitable applications only 5 scholarships were taken up in 1952. Several of our most successful candidates had previously given good service as district nurses and midwives in the County.

Refresher Courses.

It was our intention as part of the health visitors scheme to maintain a small team of relief health visitors who would be available for dealing with emergencies in any district throughout the County and for relieving health visitors who were due to go to a refresher course. It has not been possible to organize a team of this kind and, consequently, it is difficult to release health visitors for residential refresher courses. Throughout the year there is a bewildering variety of short courses for health visitors held in London which could be attended by our staff without undue interference with their routine duties. Some of these courses are held in the evenings, others at the week-end, but one is reluctant to direct staff to attend refresher courses in off-duty time. Many of the courses, too, have in the series of lectures several which are of little value to health visitors. We are well aware of the need for refresher courses and the health visitors themselves have frequently stressed the importance of being kept up to date in both clinical and social medicine. The problem has been partially solved by arranging (in duplicate where possible) a series of lectures. The subjects and the speakers are often suggested by the health visitors themselves and the meetings are arranged in towns convenient to the majority of the health visitors. By duplicating the lectures we tried to avoid taking too many of the health visitors off routine duties on the same day. An attempt was made to meet this difficulty in another way. A tape recording was made of one lecture in the hope that it would be played back to the health visitors in small groups on Saturday mornings. The experiment was not a success, however. The value of the lecturer's personality was completely lost and it was not possible to record the questions and answers to the discussion which followed the lecture.

By inviting staff from other departments directly or indirectly concerned with the subject of the lecture we have been able to make the work of the health visitor known to other departments and in turn have been able to learn much of the detailed work of officers concerned with other aspects of the social services.

During 1952 the following lectures were held and the Children's and Probation Departments were represented at one or more of these lectures.

" The Public Nurse in relation to other Social Workers."
" Child Psychology."
" Behaviour Problems in Young Children."
" A Child in Hospital."
" Teaching Methods."
" Criminal Offences."
" Marriage Guidance."
" National Society for the Prevention of Cruelty to Children."
" Modern Methods of Breast Feeding."
" Probation Work."

The need to bring the health visitors into closer association with other

members of the staff was the outcome of a high level inquiry in this County into the reasons for juvenile delinquency. The health visitors played quite an important part in furnishing evidence to the committees but a study of this evidence has shown how little the health visitors knew of the work of other officers and how little was known of the health visitors' work. These "get-together" meetings have been of great value quite apart from the subject matter of the lecture for which the meeting was convened.

SECTION 25—HOME NURSING.

This service is now directly administered by the Local Health Authority. The duties of the 137 Nurses employed in Home Nursing vary. In many rural areas the "all-purpose nurse" combines Home Nursing with Midwifery and Health Visiting. In urban areas the Nurse may divide her time between Home Nursing and Midwifery. Alternatively she may be primarily a Home Nurse or a midwife and do a limited amount of work in another field.

In some of the larger towns Home Nursing is a separate service.

There are no official schemes for co-operation between the Home Nurse and the General Practitioner. It is doubtful whether anything would be gained by promoting official schemes of this kind because the level and standard of co-operation between the Doctor and the Nurse necessarily varies with the ability, skill, and disposition on either side. The principle and tradition of co-operation have for long been accepted in Hertfordshire. Any suggestion that a District Nurse is failing to co-operate closely with the Doctors in whose area she works is followed up but complaints on this score are seldom received and less often substantiated. On rare occasions one has even had to set a limit to the degree of co-operation because it was found that the General Practitioner looked to the Home Nurse for services which were certainly not part of her duties. If the title Home Nurse is interpreted strictly her work could, of course, be limited to nursing in the homes of the people. Quite often she does dressings for patients who visit her at her house and this is accepted as part of her work. A suggestion, however, that it is proper for a Home Nurse to be called upon to attend at a Surgery to do dressings for the Practitioner is not accepted.

In one of the smaller towns of the County we have continued a long-standing arrangement whereby the District Nurses visit a Local Factory each morning to deal with minor injuries and ailments amongst the workers. The firm makes a payment for this rather irregular service which has continued to be countenanced because there is no objection to the arrangement in the local circumstances. Without it the Management would be faced with the task of finding a part-time Nurse or employing unnecessarily a full-time Nurse at the factory. Alternatively they would have to release members of the staff each morning to visit the Home Nurse. The Nurses themselves are emphatic that the scheme is in the long run a saving of their time because injuries are properly treated from the outset and recover more quickly.

There has been no call for interchange of nursing staff with the Hospital and none has been suggested. Most of our Nurses held senior appointments in Hospital before taking up Local Health Authority work. Yet one has found that in any scheme put forward by the Hospital Authorities for our Nurses to help them out in times of difficulty it is assumed that the Public Health Nurses or Midwives, as the case may be, will be prepared to act in some sub-ordinate "stop-gap" capacity. This is quite understandable to anyone who has had experience in organizing emergency staffing arrangements in hospitals, but it is not unnaturally most unpopular with our Nursing staff, except in a genuine emergency. A periodic interchange of staff between Local Health Authority and Hospital Services would undoubtedly be a good thing for each but it would have to be done more officially and more formally than has been suggested hitherto.

Types of Case attended by Home Nurse.

There is no analysis of the cases attended by Home Nurses beyond that which is required for the Ministry of Health return. This shows

	Medical, Surgical, and General.		*Tuberculosis Nursing.*	
	Cases.	*Visits.*	*Cases.*	*Visits.*
1948 . .	12,317	252,683	213	6,151
1949 . .	14,103	297,429	162	6,460
1950 . .	14,437	317,169	298	10,887
1951 . .	14,939	314,498	272	9,579
1952 . .	14,935	305,766	272	7,577

One has, however, had occasion to look into the work of the Home Nurses in some detail and has formed a general impression of the scope of their work though this impression cannot be supported by any statistics. It was expected that the National Health Service would make very heavy demands for Home Nursing and, in our Proposals provision was made for Home Nurses on a ratio of 1 : 8,000 population in Urban and 1 : 7,000 in Rural areas. In 1947 the overall ratio for the County was 1 : 9,000 population and in 1952 it was 1 : 8,500 population. At the close of the year 1952 the ratio of Home Nurses varied as between districts from 1 : 6,000 in Watford and District to 1 : 10,000 in Hoddesdon. Considerable publicity has been given to widely varying estimates of the ideal ratio for Home Nursing. It would be very helpful to Administrative Officers if official and quasi official Nursing Organizations could support the opinions they express on this subject with some data.

Our records in this County do not show any increased demands on the Home Nursing Services since the introduction of the new scheme, despite the fact that it is now a free service. The average number of visits paid per day by a Nurse was 12 in 1947 and 12 in 1952. Home Nursing, too, appears to have lost some of its interest. At one time a District Nurse could reckon to have a proportion of acute cases which gave scope for the exercise of the higher Nursing skills. The tendency nowadays is to send the person who requires expert Nursing into Hospital and, of course, recent therapeutic advances have greatly reduced the incidence and duration of the type of case which in the past called for skilled Home Nursing.

These same advances and treatment have made new demands on the Home Nurse inasmuch as they are now called upon to carry out treatments with many of the new antibiotics and chemo-therapeutic preparations which have to be given by injection in accurate dosage at regular intervals. This work is done under medical instruction but not under direct medical supervision. It is a tribute to the careful technique of our Nursing staff that so far no untoward incident has resulted from this new development. It is not so long ago that therapeutic injections were regarded as the responsibility of a Doctor which should not be delegated to a Nurse.

From time to time when making inquiries about long-standing bedridden cases in connection with the Home Helps or Medical Loan Schemes it is found the case is unknown to either the District Nurse or Health Visitor. This is, of course, quite wrong. These cases should be visited from time to time to make sure that the standard of Nursing Care which the patient receives is sufficient for her needs. The fact that these cases exist may be accounted for by the fact that the disease has led to a slowly increasing incapacity during which the relative has learned to give the patient the care required.. It may be due in part to the tradition that the Nurse must not be bothered if this can be avoided. One could wish that the same consideration could become a tradition in our Home Helps Service. During the past five years one has come to the conclusion that except in the towns with a constant heavy and predictable Nursing load there is scope for a study of the ways in which a District Nurse's duties might be reviewed. The contrast between the output of the single purpose Home Nurse in a slack district and that of her all purpose colleague in a similar district

suggests that either one is not being fully occupied or that the other is being asked to do too much.

Refresher Courses.

Until recently there have not been any suitable refresher courses for Home Nurses within easy access of this County and the staffing position made it impracticable to send staff to remote residential courses.

District Nurse Training.

The Nurses Home in Watford is approved as a Queen's Key Training Home. The Superintendent, the Assistant Superintendent, and the $10\frac{1}{2}$ Staff Nurses are engaged in training the 10–14 students who come to this Home to qualify as Queen's Nurses. These Student Nurses are required in the course of their training to have a certain amount of experience of District Nursing in Rural conditions and arrangements are made for the students from Watford to be posted for the necessary time to suitably experienced Nurses in Rural parts of the County. Similarly we arrange to take Students from District Nurses Training Schools in London for experience in Rural Nursing conditions. Apart from the Nurses who pass through the Watford Training Scheme in the course of the year 15–20 Nurses from other Training Schemes came to the County for this type of rural experience.

Overseas Nurses.

Not infrequently nurses from the Empire and elsewhere seek opportunities to gain nursing experience in this County. A number of these students are posted to this County and several interesting and useful nursing contacts have been made in this way.

SECTION 26—VACCINATION AND IMMUNIZATION.

Vaccination.

There has been no public propaganda directed towards ensuring wider use of vaccination. There were several reasons for this. One wanted to see what the public reaction would be to vaccination being no longer compulsory. Our records show in 1947 there were 3,405 vaccinations done by public vaccinators in a year when 11,065 children were born. In 1952 there were 3,979 children under one year vaccinated in a year when there were 9,341 births.

It was part of our Scheme under Section 26 that vaccination should be offered at our Infant Welfare Centres but the fact that the child had to be seen a week after vaccination meant that the scheme had to be limited to the more populous centres with weekly sessions. It soon became apparent that the demand for vaccination at these Centres without any stimulation on our part was likely to be as great as we could cope with having regard to the difficulty of recruiting suitable staff. Then again any suggestion that there should be public propaganda to encourage vaccination immediately brought one up against the difficulty of deciding what policy would be advised in regard to the vaccination of the older age groups. There seemed to be a likelihood that propaganda would lead to a demand for vaccination in older children and young adults which we would feel obliged to discourage in present circumstances. We therefore decided to work unobtrusively towards ensuring that all infants in the County were vaccinated before they became one year old. This would mean that in time we would have a population which could confidently be vaccinated if smallpox were to occur in epidemic form. As will be seen from

the table shown on page 66 considerable progress has been made in achieving this object even without any intensive propaganda. Mothers are advised by Health Visitors and Medical Officers at Welfare Centres to have their infants vaccinated and told that the Family Doctor will do the vaccination without charge. Even so, during 1952, 1,954 vaccinations were done at the Welfare Centres. From remarks made by Practitioners and a study of the records of the prophylactic materials issued to Practitioners and returns received from them it is apparent that quite a number of Practitioners are carrying out vaccination and Diphtheria immunization but not completing the record forms. Thus our figures of protective procedures amongst the children in the County are an under-statement. It will be interesting in a few years time to compare the number of infants immunized according to our records in a given year with the number returned as having been immunized or vaccinated when that particular age group goes to school.

Diphtheria Immunization.

There has been no recent *ad hoc* propaganda on this subject either, though naturally it is given a very important place in the teaching of the Health Visitors and the Medical Officers in our Centres. Birthday cards are in use in several of the Divisions. Immunization should, of course, be completed by the first birthday and the card has been designed to serve the double purpose of congratulating those who have had the foresight to have the child immunized and reminding those who have forgotten about it. Some years ago a letter was sent to the parents of school entrants reminding them of the need for boosting doses of Diphtheria prophylactic. This letter had an excellent response and it is now used as a routine in some Divisions, and in others as a stimulant when the number of immunized child entrants show signs of falling. In some Divisions a second boosting dose is given at age ten as a routine. Our School Minor Ailment Clinics are now widely used for Diphtheria Immunization Sessions.

It is obviously important that public confidence in Diphtheria Immunization should not be impaired in any way and for this reason it has been our practice to stop offering immunization in any district in which two associated cases of poliomyelitis have occurred. One realized that this precaution was probably unnecessary and that the public might be reluctant to accept immunization when it was offered again but apparently the public confidence has not been impaired in any way. Before there was any suggestion of association between poliomyelitis and immunization in 1947 there were 11,065 births, 8,035 children were immunized. In 1952 with 9,341 births, 7,652 children were immunized.

Whooping Cough Vaccination.

The policy on protection against Whooping Cough declared in our Proposals in 1947 was followed until the end of 1952. Two Districts had obtained permission to use Whooping Cough Vaccine prior to the Appointed Day. This approval was retained but in practice it has been used only in Watford. There has been a steadily growing demand by the public for protection against whooping cough in recent years. The Health Committee were advised against adopting a scheme for Whooping Cough Immunization in the first instance because the vaccines available at that time couldn't confidently be recommended but it has often been difficult to decide how far one was justified in discouraging the rising public appetite for whooping cough protection. In these circumstances a compromise seemed to be justified and it was made known that though we would not offer whooping cough protection at our Infant Welfare Centres the Medical Officers at these Centres would be prepared to give the injections for any mother who brought the necessary materials which could be obtained free on a prescription from the family doctor. The only merits claimed for this scheme were (1) that it saved the General Practitioner the time necessary to

give the three injections, (2) that the mother was saved the time and necessity of attending the Doctor's Surgery on three occasions and (3) that it did to some extent retain the public interest in whooping cough vaccination and accustom them to the idea of looking to the Welfare Centres for this form of protection. It has been very obvious for some time past however that some of the Assistant Medical Officers as well as many of the mothers attending our Centres resented the fact that we had no official scheme for supplying whooping cough prophylactic and it was with very genuine satisfaction that one was able to advise the Health Committee in December of 1952 that the preparation of whooping cough vaccines had now reached the stage at which a scheme under Section 26 could confidently be recommended. It is interesting to look back and compare the incidence of whooping cough in the area in which whooping cough vaccine has been supplied with the incidence in comparable populations in which this has not been done.

In Watford Borough (population 73,000) during the four years 1949, 1950, 1951, and 1952—the first complete years of the new scheme for which figures are available, 1,701 children were protected against Whooping Cough, 311 cases were notified, and there were no deaths.

In the same period in Barnet and East Barnet (population 65,000), where there was no whooping cough immunization scheme 830 cases were notified, and there was one death.

These figures, of course, discount any protection given by the family doctors in the two areas. The figures are too small for any deductions to be made from them but they certainly make one thankful that there is no longer any justification for discouraging the use of whooping cough vaccine throughout the County.

SECTION 27—AMBULANCE SERVICE.

The use made of the Ambulance service during the past five years is shown in the table on page 69.

Special Arrangements with Hospitals.

Some years ago the Hospital Management Committees were asked to nominate in each hospital one officer who would be responsible for seeing that ambulances were used only for cases in which Medical Authority for the use of an ambulance had been obtained. More recently a letter was sent by the Chairman of the Health Committee to the Chairmen of the various Hospital Management Committees drawing attention to the increasing demand made on the service by the Hospitals and inviting the Hospital Management Committees to review the arrangements for ensuring that the service was not used unnecessarily.

Special Arrangements with General Practitioners.

The use and abuse of the Ambulance Service has been brought up for discussion on several occasions at the Local Medical Committee. At a meeting in 1950 several of those present made two very important points : (*a*) the public were under the impression they were entitled to an ambulance on demand. Many patients were irritated by the weekly contribution to the Insurance Fund which they invariably regarded as being devoted entirely to Medical Services. Patients quite frequently said that this was one of the few opportunities of getting value for money and they insisted on having an ambulance, and (*b*) the General Practitioners had never been told precisely how the ambulance service was to be used and without this information it was difficult for them to refuse to authorize one. Cases were even quoted in which patients had threatened to try to find a more accommodating Doctor if the certificate were withheld. To meet these points a letter was sent out to all Practitioners in

the County defining the type of case for whom the ambulance and the Hospital Car Service was intended. With this letter was a printed card which read " A person may be ill but still able to use a bus, train, taxi, etc. Ambulance and Hospital cars are strictly reserved for those who for medical reasons cannot use any form of public transport. Your Doctor has been asked not to order an ambulance or Hospital Car unless it is absolutely necessary." Despite this action, however, the demand on the ambulances continued to increase and at the suggestion of the Medical representative on the Health Committee the statistics on Ambulance calls are now broken down to show whether they come from a General Practitioner, a Hospital, or from other sources. These statistics show that the use made by the General Practitioner of the ambulance service is relatively modest. The heaviest demand comes from the Hospital Out-patients' Departments. The existence of an efficient ambulance service, for example, makes it possible for a Chest Physician to arrange for bed-fast patients to be brought regularly from their homes to the Clinics for some quite elaborate forms of surgical treatment and thus save admitting these patients to Hospital. The considerable cost of these cases to the ambulance service is of course off-set by a much greater saving to the Hospital Service. Again a case may be brought up to a Hospital Out-patient Department for a consultation and a date for a re-visit is arranged. An ambulance was necessary for the first visit and an ambulance was automatically arranged for the re-visit. Quite often it was found that the re-visit could have been made by public transport and advance bookings are now subject to confirmation before the trip is arranged. The physiotherapy clinics give the greatest scope for vigilance on the part of the Hospitals. A treatment is ordered at a time when the patient is too crippled to attend except by ambulance. In time this patient recovers to the stage at which public transport could be used but the case may not be reviewed. Alternatively the patient may live at a place where there is no public transport at a time convenient to the hours during which he is to attend for treatment. The financial and practical difficulties of getting this patient to Hospital are so formidable that a point is stretched and the ambulance is continued.

There is also a very heavy strain on the ambulance service in this County, as in all the Home Counties, by virtue of its relation to the London Teaching Hospitals and Special Treatment Centres. The habit of looking to London for all but the simplest forms of treatment has persisted despite the elaborate services which are now available in the County. Many General Practitioners, of course, trained at London Medical Schools and still look to their Clinical Teachers for help with difficult cases. A substantial proportion of Out-patients at London Teaching Hospitals come from the Provinces.

In the old days the fee-paying patient made his own way to the selected Specialist or if too ill to do so the patient was admitted to the private wards of a local hospital and the Consultant came down to see him and if necessary arrange the treatment. Nowadays private wards are beyond the reach of most of us and the patient has to be sent to the Consultant. He understandably may order treatment or investigation at the Hospital or Clinic with which he is associated; consequently there are many people in this County travelling weekly or more often over long periods for treatment in London. These trips for consultation or special forms of treatment are undoubtedly justified in a " free choice " service. Occasionally one finds frequent journeys being made to obtain forms of treatment which can easily be obtained in Hertfordshire and in these cases the General Practitioner is asked to agree to local treatment being arranged.

All requests for trips of more than 50 miles are referred to a senior Medical Officer on the County staff. Decisions on these cases are often difficult and harrowing. On occasion one sanctions a long journey to enable an accident case in hospital to finish his convalescence at home or to allow the moribund case to die at home. This is in the interests of the patient and of the National Purse but it can become a heavy charge on the Ratepayer.

SECTION 28—PREVENTION, CARE, AND AFTER-CARE.

Tuberculosis.—Five Chest Physicians work at 7 Chest Clinics in this County. The Royston Urban District is served by the Cambridge Chest Clinic. The County Council has agreed to pay a proportion of the salary of the Chest Physicians but the precise proportion has not yet been decided upon. Each Chest Physician has the services of an Almoner and whole-time Tuberculosis Visitors. In two Chest Clinics Clerical help for the Almoner and T.B. Visitors is supplied by the Local Health Authority. Elsewhere these officers look to the clerical staff of the divisional offices. The Table which follows shows for each Chest Physician the population he serves, the number of cases on his register, and the staff supplied by the Local Health Authority.

DECEMBER, 1952.

Chest Clinic.	*District Served.*	*Population.*	*No. of Tuberculosis cases on Register.*	*Staff.*
Hitchin	Hitchin Urban	19,980	152	1 Almoner (part-time).
	Hitchin Rural	22,210	136	
	Stevenage Urban	7,886	57	1 Health Visitor.
	Letchworth Urban	21,040	254	
	Baldock Urban	6,304	47	
Hemel Hempstead	Hemel Hempstead Borough.	26,170	278	1 Almoner (part-time).
	Hemel Hempstead Rural.	11,940	129	1 Health Visitor (part-time).
	Berkhamsted Urban	11,410	104	
	Berkhamsted Rural	5,716	40	
	Tring Urban	5,240	34	
Watford	Watford Borough	73,200	690	1 Almoner (full-time).
	Watford Rural	43,340	640	
	Bushey Urban	16,520	148	3 Health Visitors (full-time).
	Rickmansworth Urban.	25,180	213	1 (part-time).
	Chorleywood Urban	4,586	24	
St. Albans	St. Albans City	44,700	273	1 Almoner (part-time).
	St. Albans Rural	29,010	219	
	Harpenden Urban	14,650	60	2 Health Visitors.
	Welwyn Garden City Urban.	19,190	164	
	Hatfield Rural	24,550	178	
	Welwyn Rural	5,353	35	
Barnet	Barnet Urban.	24,920	202	1 Almoner (part-time).
	East Barnet Urban	40,780	372	
	Elstree Rural	16,700	245	2 Health Visitors (full-time).
Hertford	Hertford Borough	13,340	86	1 Almoner (part-time).
	Hertford Rural	8,751	50	
	Braughing Rural	10,400	75	1 Health Visitor (part-time).
	Ware Urban	8,391	62	
	Ware Rural	11,230	79	
	Hoddesdon Urban	14,260	90	
Waltham Abbey	Cheshunt Urban	23,880	193	1 Almoner (part-time). 1 Health Visitor (part-time).
Bishop's Stortford	Bishop's Stortford Urban.	13,270	70	1 Almoner (part-time).
	Sawbridgeworth Urban.	3,878	15	1 Health Vsiitor (part-time).

Co-ordination of the work of the Chest Physician in his respective spheres as an officer of the Hospital Board and of the Local Health Authority is of a high order, since the running of the services in both capacities is largely left to the Chest Physician. On the Local Health Authority side the Chest Physicians meet in Conference quarterly under the Chairmanship of the County Medical Officer. At these Conferences the Chest Physicians discuss problems associated with the preventive side of their work and the County Medical Officer initiates discussions on items of common interest particularly those on which it is his duty to decide policy for the guidance of the Chest Physicians. The wide variation in the number of staff employed in the various clinics is evidence that there has been no attempt to impose a County Scheme on the Clinics and that the work in the various areas is allowed to develop according to the idea of the Chest Physician concerned on what is possible and what is worthwhile.

At the outset of this scheme there were fears that the preventive side might suffer through being entrusted to Physicians who were pre-eminently clinicians. These fears have not been justified. This may in part be due to the upgrading of the Chest Clinics by the Hospital Boards, to advances in diagnosis such as mass miniature radiography and skin testing techniques, and to modern methods of treatment and consequent reduction in the period of infectivity. In 1947–48 the estimates provided the sum of £132,478 for the County's comprehensive tuberculosis service. In 1953–54 our estimates provide £24,057 for the preventive side of the service only. No information is available as to the sums spent by the Hospital Boards on the Clinical tuberculosis service in this County but the scale of the service is perhaps indicated by the fact that some of the individual Chest Clinics now have clerical staff greater than that which was employed for the whole of the County service in 1947. These changes entitled one to expect results and results are now being seen but it would be ungenerous to suggest that they have flowed purely from the material resources brought into the battle. In this County, at all events, the Chest Physicians have taken a very real interest in Prevention.

A great deal of time, energy, paper, and diplomacy have been expended unnecessarily in trying to determine our respective responsibilities in the new tuberculosis scheme. The Ministry of Health's unwillingness to interfere or issue directions to Local Health Authorities on the manner in which they should develop this service is commendable but it would have been helpful if they could have been given guidance on certain points, e.g. the need for and the duties of the Almoner and Tuberculosis Visitor respectively. It should have been possible too to have given a ruling on the responsibilities of the Local Health Authority and the Regional Hospital Board in regard to the Chest Clinics. Is a Chest Clinic comparable with any other Hospital out-patient department except that the Chest Physician is allowed to use it for preventive work ? Is the Local Health Authority allowed to attach Almoners and T.B. Visitors to the Clinics so that they may acquire the information necessary for them to perform their Local Health Authority duties or are these officers part of the out-patient team while working in the Clinics ? Conversely are the clerical staffs appointed to the Clinics by the Hospital Management Committees expected to handle records relating to contacts and to keep the files required by the almoner in the course of her work ? It has been argued that a Chest Clinic is unique in that it is a joint responsibility in which the cost of providing and maintaining the Clinic should be shared jointly in proportion to the work done on behalf of the Hospital Board and the Local Health Authority. This argument logically brings one back to the starting point. Many of us argued that it was impossible rationally to separate the two sides of the tuberculosis service. The Act decreed otherwise. It should now be possible to issue some directions on these technical administrative points. It has been agreed that the scheme is working, that co-operation exists, and that the results are good, but this has been achieved by an expenditure of time and energy which could be better spent in other directions. The three Hospital Boards which serve this County

all have their own ideas on interpretation of the Scheme and each has convincing arguments as to why its ideas are the right ones. It is difficult for the administrator to operate at County level a scheme which is dependent on co-operation with Officers employed by Hospital Boards with a diversity of views on matters of detail. A County Health Committee may be forgiven for wondering why the Hospital Boards which are agents of the Ministry of Health cannot be given some direct guidance on this question of their relations with the Local Health Authorities in the tuberculosis scheme. The Local Health Authorities and the Hospital Management Committees are keen to do their job well. It should be possible to simplify their tasks by a declaration of the Ministry's views on co-operation without in any way trespassing on the legitimate autonomy of either the Hospital Committee or the Local Health Authority.

Other Illnesses.—Earlier in this report it was noted with regret that there was no official scheme for After-Care in operation between the Hospitals and the Health Authority. It is understandable that the Hospital medical staff don't want to deal with two lots of social workers, and that the Hospital Almoners feel that if they are to be debarred from home visits, they will be content with Hospital Almoning which follows the pattern in which they were trained. Difficulties in recruiting staff have prevented us from putting forward a claim that we should be brought into the picture but there is no doubt that the Health Visitors have information on the home background of families, especially those with young children, which would be of great value to those treating patients in Hospitals and that a recognized link with the Hospital Services would enhance the prestige of the Health Visitor in her dealings with her public.

A certain amount of after-care work for hospital patients has in fact been done in this County as a result of the good relationships which exist between the Hospital and the County Almoners but this is too personal to be entirely satisfactory and the increasing preoccupation of our almoners with the tuberculosis service will inevitably lead to a decline in the little that has been done. There is, of course, co-operation between the Hospital Almoners and our Home Nurses, Home Help Organizers, and Midwives, but this is merely a necessary integration of the two services and not in any way an After-Care Service such as was intended by Section 28 of the Act.

SECTION 29—DOMESTIC HELP.

The story of our Home Help Scheme is one of the more remarkable features of the Health Services in the past five years in this County and but for the fact that the financial brakes had to be applied some years ago the story would have been even more remarkable. It is difficult to say how far this service has developed to meet a need which has been recently created by changing social circumstances and how far the need has existed unrecognized and uncatered for in the past. It is probably true to say that the Home Help Service, and the Day Nursery Service, have done as much for " After-Care and Prevention " as anything that has been done under Section 28. In their Proposals the Health Committee faced up to the possibility that this Home Help Service might develop an appendage to the Home Nursing Service to such an extent that there would be a demand for a team of Home Helps equivalent in strength to that of the Home Nursing Services. At that time the County employed the whole-time equivalent of 24 Home Helps. Within two years the Home Help Service had far outgrown the Nursing Services, both in numbers and cost. Our estimates for the five years past tell their own story.

Year.	*Strength in whole-time equivalent.*	*Total expenditure.*
		£
1948–49	100	26,142
1949–50	270	60,869
1950–51	330	89,857
1951–52	315	87,039
1952–53	250	75,076

But for the fact that charges had to be made for Home Help Services, and that it was thus possible artificially to limit the demand, there is no doubt that it would have been necessary to maintain the strength at the 1950 level. The charges for Home Helps in a predominantly free Health Service, have puzzled and irritated the public and, as shown in previous reports, have been criticized by Chest Physicians and others who are dependent for their results on the patient being able to rest at home. Expenditure on Home Help is, of course, reflected in a saving in the Hospital Services and the cost of maintaining homes for old folks but, as with the Day Nurseries, it is difficult to persuade any Committee to inflate its own budget in order to reduce that of another Committee or to effect a saving in tax borne expenditure.

Training.

There is no scheme for training Home Helps. The idea of inaugurating training schemes was considered but shelved in the early days. At that time there were constant adjustments in the rates of pay and consequent changes in the charges made and in the net cost of the service. These adjustments were made in the endeavour to attract the right type of Help, to keep the charges reasonable for the user, and the cost of the service acceptable to the Finance Committee. The Health Committee, had they been asked, would no doubt have encouraged the idea of the training scheme to improve the standard of the work by the Home Helps and to give the service the status which it deserved, but a training scheme would have meant examinations and worthwhile additions to the pay of those who were successful in these examinations. It was felt that the money available was better spent on meeting the demand from the public who by and large were well satisfied with the standard of service offered. More recently the decline in the number of Home Helps employed in this County has made it possible for the Organizers to select those known to have the necessary experience and ability.

HEALTH EDUCATION.

It cannot be claimed that there has been any progress in this direction as a result of the National Health Service Act. Reference has already been made to the work of the Health Visitors at the Welfare Centres and at the Mothers' Clubs, and to my opinion that the Day Nursery in its limited sphere of influence is probably the most powerful propaganda agent available to a Health Authority.

Some Divisional Medical Officers, as District Medical Officers of Health, have organized health weeks and other propaganda drives in their areas. A considerable amount of Health Education on the question of food hygiene was carried out as a result of introduction of the new bye-laws. In several Districts it was found that the attendances at Food Hygiene Lectures were very poor and that the only way to ensure an audience of the people one really wanted to talk to was to get the employers to allow their staffs to attend lectures during working hours. The Education Committee had readily agreed that the food hygiene bye-laws should apply to the school canteens and a considerable amount of educational work has been done among the staffs of these canteens, either by way of lectures to the canteen Supervisors who, in turn, pass on the information to their staffs, or by direct lectures to the staffs of the canteens.

The National Health Service Act, of course, indirectly led to the appointment of the Divisional Medical Officers, and the existence of active Health Departments headed by experienced Medical Officers throughout the County has, undoubtedly, done much to educate the public in the work of the Health Departments.

There is no doubt that there has been a change in the public reaction to the edifying lectures of various aspects of healthy living on which we used to depend. Many Medical Officers have reported that well advertised lectures

have attracted only the faithful few, who have turned up from a sense of loyalty to the Lecturer, or from an appreciation of the importance of the subject under discussion. Fifteen years ago the Headquarters staff of a Health Department could expect a steady demand for lectures on various health subjects. The war of course interrupted this demand and since then the Headquarters staff has been too pre-occupied in sorting out tangles of the new Health Service to attempt to stimulate public interest in Health Education. Nevertheless, the practice of applying to Headquarters for lectures has grown up again. But whereas at one time the request was for lectures on specified Health subjects, nowadays it is for talks on the organization and purpose of the Health Services. Invitations of this kind are wherever possible accepted. Admittedly the subject does not rank as Health Education but I have no doubt that at this phase in our affairs it is more profitable to educate the public in the structure, use, and aspirations of our services than to attempt to lecture on specific aspects of healthy living. The field for Health Education has changed. Many of the established truths of our former Health propaganda are now accepted by intelligent people as part of the way of life, and attempts to expatiate at length on these matters is welcomed only by those who " lap up " any lecture on any subject which has a bearing on Health. Our faith in some of the " fundamental truths " of Health Education were, of course, shaken badly by our experience during the war and the emphasis which one could place on certain points has been changed by the development of modern forms of treatment. One can foresee the time when it will sometimes be simpler to catch a disease and be cured than to bother about avoiding catching it. The good old " hell fire " attitude to health is no longer appropriate. While the fundamentals of Health Education are being shaken the refinements of education in the ideal of " Mens Sana in Corpora Sano " are as yet not understood. Lecturers on this theme tend to be dictatorial on matters which are still conjectural or alternatively to deliver themselves of a vague collection of meaningless platitudes or of exhortations to behave and think in certain ways. Since we have not yet learned the art of adding to our mental or physical stature by taking thought, this kind of thing is of little value. Our whole approach to Health Education requires recasting. The surviving defects in our environment which affect our physical health have ceased to be of importance in comparison with those things which affect our happiness and mental health. Health Education can never regain force until the root cause of these things are understood. When they are understood it may well be found that they are so complex that it will be found expedient to have expert specialist lecturers to explain the broad facts of health through the media of radio, television, and the Press, leaving the Medical Officer of Health and his staff to emphasize and enlarge on this National propaganda and to encourage its application in the daily life of the people.

MENTAL HEALTH.

Administration.

(*a*) *Committee.*—There is no Mental Health Sub-Committee in this County. Prior to 1948 the Committee work associated with our Mental Deficiency Schemes was done by the M.D. Colony Committee. This Committee was interested primarily in the running of the Institution and the County Medical Officer was given wide discretion in his care of the domiciliary cases. There was consequently no demand for a Mental Health Sub-Committee when the Colony Committee was abolished. It has been found the Health Committee can deal adequately with the Committee work necessary in running and developing the Mental Health Service.

(*b*) *Staff.*—In 1948 the prospect of running a Mental Health Service apart from the Mental Hospitals was viewed with some alarm and provision was

accordingly made in our Proposals for the following staff in the Mental Health Section :—

> 1 Medical Officer (Mental Health), 1 Administrative Officer, 2 whole-time Psychiatric Social Workers, and at least 7 part-time Authorized Officers.

There was no case for appointing a Psychiatrist or a Psychiatric Social Worker as long as the link with our former Institutions could be retained and everything was done to preserve it. Consequently the staffing and the administration in the Mental Health Section were deliberately left fluid in the early days of the changeover and there has been no reason to regret this action. The Social Workers in Mental Health, however, had previously worked in very close association with the Medical Superintendent of our Deficiency Colony and were guided by him in the formalities and responsibilities of their work. When the institutional and domiciliary work was separated the Social Workers tended to devote too much time to the office work concerning the legal aspects of the Mental Deficiency Service and not enough time to domiciliary visiting of patients living in community care. About the same time, on the School Health side, we were finding difficulty in deciding upon a satisfactory routine for the ascertainment of educationally sub-normal and maladjusted children. These problems, which were overlapping to some extent were both solved by putting the clerical work of the Mental Health Section under the Clerk in charge of School Health. The Mental Health clerical section now handles all the work connected with the mentally handicapped children on the educational side as well as the domiciliary work associated with the care of mental defective and the mentally disordered. It also does the clerical work of the Child Guidance Service in so far as it is done centrally. The Child Guidance Staff includes a clerical section which deals with the running of the clinics, appointments for patients, and reports and correspondence on all matters of detail. The County Council has agreed to pay a proportion of the cost of the staff. The staff of the Mental Health Section may then be summarized as follows :—

Medical.

County Medical Officer and Deputy and Divisional Medical Officers advised by the Director of the Child Guidance Service on Child Guidance cases and the Educationally Sub-Normal and by the Medical Superintendent of the appropriate Mental Hospital or Colony on disorder and deficiency. Eleven of the Medical staff are approved by the Ministry of Education for the ascertainment of Educationally sub-normal pupils.

Social Workers.

There are four social workers, one of whom specializes in the organization of the Occupation Centres. Each of these Officers has an area of the County in which she is responsible for the domiciliary care of the Mentally Defective.

Psychiatric Social Workers and Educational Psychologists.

The Education Committee have agreed to pay the whole cost of the Educational Psychologists and a proportion of the cost of the Psychiatric Social Workers employed by the Mental Hospital in the Child Guidance Service. The limited amount of After-Care done in the field of mental disorder is undertaken by one of the County Almoners.

Duly Authorized Officers.

The Chief Welfare Officer allots 3 per cent of his time to his duties as Senior Authorized Officer and the 7 Welfare Officers and 8 Assistant Welfare Officers give 35 per cent of their time to duties as Duly Authorized Officers.

Occupation Centres.

One Social Worker gives 80 per cent of her time to the work of setting up Occupation Centres, finding premises and staff, arranging transport, and co-ordinating the running of this branch of the Service. There are 5 Supervisors, 7 Assistant Supervisors, and 5 Helpers and Escorts. All the Supervisors and 3 of the Assistant Supervisors have had training.

(*c*) *Co-ordination.*

Child Guidance.

This County has always stressed the value of a link between the Child Guidance Service of the Local Authority and the treatment services for children run by the Hospital Authority. An arrangement has therefore been arrived at, by which both the Local Health Authority and the Regional Hospital Board put premises at the disposal of the joint diagnostic and curative service. Proposals for an allocation of responsibilities for staff have been approved by the Education Committee. The precise form of the scheme is not yet finally agreed but it has continued to function well.

Disorder.

In July, 1948, the County Medical Officer convened a meeting of the Medical Superintendents of the Mental Hospitals serving the County, and the Duly Authorized Officers. At this meeting the Medical Officers defined the policy which they hoped to adopt, and discussed its application with the Duly Authorized Officers. As a consequence the co-operation between these Officers has been invariably of a high order. The inability to maintain observation wards in the County has been a source of very great difficulty for both the Hospitals and the Duly Authorized Officers.

Psychiatric Social Workers.

At the same time talks were arranged with the Medical Superintendents and their Psychiatric Social Workers to find how much After-Care the Local Health Authority could usefully undertake. The Hospitals were insistent that as a general rule After-Care should be done by the Psychiatric Social Worker who had handled the patient in hospital and that the scope for After-Care work by the Local Health Authority staff must be limited to those cases which had no link with a Mental Hospital in the County, or those referred to us because they could no longer usefully keep in touch with a Hospital. There was obviously doubt as to whether there would be work for Psychiatric Social Workers on the County staff, and it was agreed that one of the County Almoners with wide experience would in the first instance, deal with these few cases. This caution was justified. The Almoner in question has averaged only 6 cases per annum. Her work though limited has undoubtedly been useful and the arrangement has, it is understood, been adequate.

Mental Deficiency.

The link with the Mental Hospitals on the deficiency side is close.

Occupation Centres.

Before 1948, two local children were attending the Colony School as " day boys ". When the number of cases of the Occupation Centre type in the area around St. Albans justified establishing a Centre, the Hospital Committee were asked if they would consider allowing our children to join the Colony School. The idea was received with immediate and sympathetic interest and, for the past three and a half years, some twenty children have been attending daily.

Training.

Our Occupation Centres have been running for several years. Some of the older children are no longer suitable for the Occupation Centre regime, and there has been a demand for facilities for training them in some useful occupation. Here, too, the Colonies have been most helpful and adult defectives are now attending daily at four Colonies in this County, where they receive training at the Craft Classes which form a normal part of the Colony routine.

Ascertainment.

Many of the cases which are ultimately ascertained as defective have passed through the Child Guidance machine which is run in conjunction with the Mental Hospital at Hill End, and a decision on exclusion from the educational system and the advice on the After-Care of children leaving our Educationally Sub-Normal Schools was till recently usually given by the Medical Director of the Clinic or his Deputy. In the same way the Medical Superintendent of the Colony has for many years undertaken the ascertainment of cases who were not suitable to be seen at the Child Guidance Clinic. He also advised the Courts on cases in which the question of mental deficiency arose.

Supervision.

Disorder.—As already noted, the Mental Hospitals have been able, for the most part, to provide their own After-care Service.

Deficiency.—The supervision of patients in community care and those on licence from Mental Deficiency Colonies who are living in this County is undertaken by our Mental Health Social Workers.

One foresaw very great difficulties when it was decided that the Deficiency Colonies should come under the jurisdiction of the Regional Hospital Board. It was claimed that this transfer was justified, because there would be a better link between General Medicine and Mental Medicine including Mental Deficiency. There is no obvious sign that the link between these three elements is any closer than it was, but the completeness of the co-operation between the staffs of the Colonies and of the Local Health Authority has certainly minimized the ill-effects of the transfer.

(*d*) *Voluntary Associations.*

There is no Voluntary Association for Mental Welfare in Hertfordshire. The National Association was used for dealing with certain types of After-care until this Service was withdrawn. Contact with this organization is maintained principally through our limited use of the Mental After-care Homes, which cater for people who can exist in the community only if they have a sheltered background. These Homes are used by Mental Hospitals for patients on licence but, once treatment is complete, the Regional Hospital Board can no longer be responsible for these patients, and the Local Health Authority may be asked to accept them under the Mental After-care scheme.

Some of the cases become very long-term liabilities, and it is questionable whether the real need is not merely for permanent shelter of the type provided by a specialized Welfare Home. Most of them are temperamentally unsuited for life in the type of small Home which is now favoured by the Welfare Committee. Institutions which remain to the Welfare Committee have already more than their fair load of the mentally disturbed or defective.

(*e*) *Training of Staff.*

Social Workers.

Two have attended Courses run by the National Association for Mental Health. One had many years' experience in general social work and in nursing before taking up mental health social work. One holds a Social Science Diploma.

Occupation Centre Staff.

Four Supervisors and one Assistant Supervisor hold the Diploma of the National Association of Mental Health. In addition one other Supervisor and two Assistant Supervisors are deemed to be qualified in two cases by extensive experience with mental defectives and one is a Registered State Children's Nurse.

Duly Authorized Officers.

Eleven of the Officers hold the Relieving Officer's Certificate of the former Poor Law Examination Board and the remaining four are all qualified by many years' experience in this work. Their practical experience ranges from four to thirty-eight years.

Plans for the schemes of training for Authorized Officers have been discussed with the Medical Superintendents of the Mental Hospitals, but it was felt that the time was not opportune. A scheme of training would necessarily be directed to the ideal methods of handling disordered patients. The lack of a sufficient number of hospital beds and of Observation Wards in this County makes it impossible to organize the ideal Domiciliary Mental Health Service, since this must in turn be combined with the ideal Mental Hospital Service.

Work Undertaken in the Community.

(a) Prevention, Care and After-Care.

The question of prevention unfortunately does not arise as yet unless one includes under this heading the inquiries into virus disease in pregnancy in which our Health Visitors are engaged.

Care and After-care have already been dealt with. In practice, our Social Workers include in their visiting lists some 111 cases under voluntary supervision of whom 19 are infants pending ascertainment. It is often found that the parent or guardian who is able to care for the defective at home welcomes regular visits by a Social Worker, and the knowledge gleaned in the course of these visits is of great value if, later, a decision on the disposal of a case has to be taken.

The Health Committee have agreed to contribute to a Social Club for Mentally Defective Women in one town in this County.

Disorder.

The limited demand for After-care has been referred to. The desirability of developing preventive work in the Mental Health field is eagerly admitted, but it is most difficult to find any line of endeavour. As already noted, many of the root causes of present-day restlessness and unhappiness lie outside the ordinary scope of the duties of the Medical Officer of Health. It was hoped that our new responsibilities in Mental Health would have brought us in touch with those who could point the ways in which we could help, but these hopes have not been justified.

In the absence of any constructive ideas, one has had to be content to try to infuse something more than the necessary element of kindliness into the administration of our Social Services. It is commonplace nowadays to meet people who would have been socially adequate fifty years ago but now are quite unable to earn a living and, at the same time, to cope with the business of living in an organized community. In varying degree, this strain has affected everyone, and it may be a factor in deciding who remains on this side of the threshold of relative sanity and who passes beyond. The administrators of public services have many opportunities of minimizing this strain in the organization of their services and manner of dealing with the public.

(*b*) *Mental Treatment Acts.*

The Duly Authorized Officers carry out the duties which formerly they discharged as Relieving Officers. As far as is known, the change of title has not affected the Service in any way but when the Mental Hospital Services can function as the Superintendents would wish, the value of bringing this work under the jurisdiction of the Medical Officer of Health will be beyond doubt.

Two of the Mental Health Social Workers on my staff were originally nominated as Authorized Officers in the belief that there might be a demand for a female officer to deal with female patients, but this service has never been asked for.

(*c*) *Deficiency.*

(1) *Ascertainment.*

The recognition of the Child Guidance Service by the Education Committee, the building up of a staff of whole-time Assistant County Medical Officers and Health Visitors, and the improved office organization over the past ten years have greatly added to the efficiency of our machinery for discovering the existence of defectives in the community. Perhaps the strongest stimulus in this direction was the 1944 Education Act and the resulting Handicapped Pupils Regulations, which made it desirable that children who were likely to require special forms of education should be detected as soon as possible.

When a child whose mental capacity is in question reaches two years of age, it is necessary to consider whether the case is likely to be classified as educationally sub-normal, in which case special education has to be arranged, or mentally defective, in which case the child will be excluded from the educational system and come under the care of the Mental Health Service. If the child is an obvious defective and is accepted by the parents as such it may forthwith be formally ascertained. This is an advantage if the child is to be removed to an institution ; but apart from this, it is better that this should be done once the prognosis is beyond doubt, since this enables the Local Health Authority to help the case by placing it under statutory supervision. It may also help the parents to resign themselves to the idea that the child will not go to school and reassure them that the Local Health Authority will take care of the child's future if anything should happen to them.

The decision to ascertain as mentally defective is not lightly taken. Some years ago the Education Committee directed that, where a child's educational future was at stake, reports made under Section 57 of the Education Act were not to be given by an Approved Medical Officer alone if there was any element of doubt in the diagnosis. It is our policy, therefore, to have the less difficult cases of this type ascertained by the Assistant County Medical Officer advised by an Educational Psychologist. More difficult cases are referred to the Child Guidance Clinic, where the Medical Director decides what investigations are necessary before a diagnosis is made. The same procedure is used where it is anticipated that the parents will make a formal objection to the child being excluded from the educational system.

It is used also in dealing with children who have actually attended school and are found to be unsuitable. The majority of these cases, of course, are referred to the Child Guidance Service for a detailed investigation.

When a child who has attended a school for the Educationally Sub-Normal reaches the age of sixteen, a decision has to be made as to whether the child should be brought under statutory supervision after leaving school, and this decision, too, has hitherto been made by the Medical Director of the Child Guidance Service. Where the question of mental deficiency arises for the first time in adult life, the diagnosis if it presents any problem is made by the Medical Superintendent of the Colony, if not, the ascertainment is done by an approved Medical Officer. Some of the more blatant cases have been maintained

in secrecy by their parents. The less obvious may have passed unrecognized through our schools, and come to the notice of the Courts or arrived in our Part III Institutions as " persons without a settled way of life ".

(2) *Supervision.*

Our Social Workers are supervising the following categories :—

(i) Friendly Supervision.
(ii) Statutory Supervision.
(iii) Guardianship.
(iv) Cases on Licence.

All supervision of defectives on licence in this County and home condition reports for cases in Institutions where the home is in this County are undertaken by our Social Workers. The cost to the Local Health Authority of this work, done on behalf of the Hospital Boards, is offset by the value of the services of the medical staff of the Colonies in ascertainment.

(3) *Occupation and Training of Defectives.*

In our Proposals, it was contemplated that one Occupation Centre and one Adult Training Centre would ultimately be set up in each of the seven Divisions in the County. There are now six Occupation Centres which provide for 147 places. The distribution is such that there are at present 141 children attending these Centres and there are 13 children on the waiting lists for four of the Centres and in the remaining two the accommodation is not fully taken up.

When Social Workers find a defective who might be suitable, the case is brought to the notice of the Occupation Centre Organizer who visits and decides whether the case is acceptable.

The area covered by the individual centres varies from 24 square miles in the case of Barnet Occupation Centre to 155 square miles in the case of Hertford Occupation Centre.

Transport is a major problem in the Occupation Centre Service. Vehicles of one kind and another cover 2,320 miles per week in order to get 121 children to and from our Centres.

The Centres meet in hired premises. These, in many ways, are primitive and inconvenient but, even so, the cost of the Service is high by comparison with the general run of the Educational Service. In these circumstances, there has been no move to provide special accommodation as long as it was possible to do without it. In South-West Hertfordshire, the difficulties of accommodation and the number to be catered for have led the Health Committee to resolve to provide a specially built Occupation Centre for 50 places.

Twenty children in the St. Albans area attend the school run for the children resident in the Cell Barnes Colony. The County Council provides transport to and from the hospital, and pays the Hospital Management Committee an agreed rate for each child.

In recent years, the parents of children attending our Occupation Centres have been critical of the curriculum laid down for use in these Centres. Parents of children showing some progress towards an understanding of the three " Rs " have asked that their children should be given special coaching in the hope—that is obvious, though not always expressed—that the child might be brought to a stage at which he could return to the educational stream. Similarly, parents of older children who have shown some evidence of manual aptitude have asked that the curriculum should be extended to include training in purposeful handicrafts which might fit the child for useful employment in adult life.

In several instances, children in the first group have been re-examined to see whether there was any case of special teaching, but there has been only one instance of an Occupation Centre child having progressed to a stage at which we could seriously consider reviewing exclusion from the educational system. As to the second group, there would obviously be great difficulty in providing the necessary equipment for craft training in the type of premises used for our Occupation Centres, and in arranging for teaching staff with the necessary experience to visit five Centres throughout the County for the purpose of training a few children whose ability to profit materially by advanced training would always be in question.

Much of the value of the Occupation Centre lies in the relief it gives to the parents, and the basic type of Occupation Centre should be made as widely available as possible throughout the County before expensive experiments of doubtful value are introduced. The logic of this argument was accepted with good grace—if with reluctance—by the interested parents.

Fortunately, it has been possible to meet the point in another way. Our proposals included the provision of a Training Centre for Adults in each Division. This proposal was not given serious consideration until recently, when children who had been attending Occupation Centres for some time reached an age when they became an embarrassment in the Centre or had progressed to a stage when they were ready for more advanced training.

The distribution of these cases was such that the greatest number who could have been brought to a Centre in any Division was eight. This number was obviously too small to justify a special new Adult Training Scheme.

Once again, therefore, we turned to the " Colonies " in the County and, as usual, found them ready to help by accepting these cases as day boys at the Instructional Classes organized for the comparable cases resident in the institution. A total of six youths and two girls is now attending daily at institutions in this County. In five instances, transport had to be arranged because of the difficulties of the journey. In three, the youths find their own way to and from the Mental Hospital. There are obvious objections to having feeble-minded young women travelling regularly by public transport and, in several instances, it has been possible to arrange for girls who have reached an age suitable for adult training to be admitted to the institution.

Home Teaching.

There is no organized scheme for Home Teaching except in so far as a person with a mental in addition to some other defect, e.g. blindness, comes under some Home Training Scheme. The Mental Health Social Workers have opportunities for showing parents and guardians suitable methods of teaching the house-bound defective. The Health Visitors, too, have been given special lectures by the Superintendent of the Cell Barnes Colony on advising parents how to handle a mentally defective child.

PART II.

ANNUAL REPORT, 1952.

VITAL STATISTICS FOR THE COUNTY OF HERTFORD.

TABLE 2.

POPULATION AND ACREAGE.

	Acreage (land and water)	Population at Mid Year			
		Estimate 1949	Estimate 1950	Estimate 1951	Estimate 1952
Boroughs	21,496	152,120	155,760	155,430	158,410
Urban Districts . . .	70,664	277,128	279,733	280,570	286,090
Rural Districts . . .	312,363	166,672	171,147	182,700	189,200
County	404,523	596,010	606,640	618,700	633,700
England and Wales . .	37,339,215	43,940,000			

TABLE 3.

STATISTICAL SUMMARY.

	Boroughs		Urbans		Rurals		County	
	1951	1952	1951	1952	1951	1952	1951	1952
Death rate . .	11·81	10·62	10·70	9·77	9·14	8·60	10·51	9·63
Live birth rate .	14·78	15·15	14·61	14·03	15·55	15·48	14·91	14·74
Infant mortality rate	28·00	22·10	22·35	20·43	23·22	14·34	24·06	18·95
Maternal mortality rate	0·43	0·41	—	0·73	0·69	0·67	0·32	0·63
Epidemic death rate .	0·04	0·04	0·08	0·06	0·03	0·05	0·05	0·05
Phthisis death rate .	0·23	0·13	0·12	0·13	0·19	0·15	0·17	0·14
Cancer death rate .	1·70	1·96	1·90	1·89	1·26	1·53	1·66	1·80
Heart disease death rate . . .	3·84	3·31	3·36	2·98	3·21	2·68	3·43	2·97

TABLE 4.—DEATH RATE, 1923–1952

Per 1,000 Population

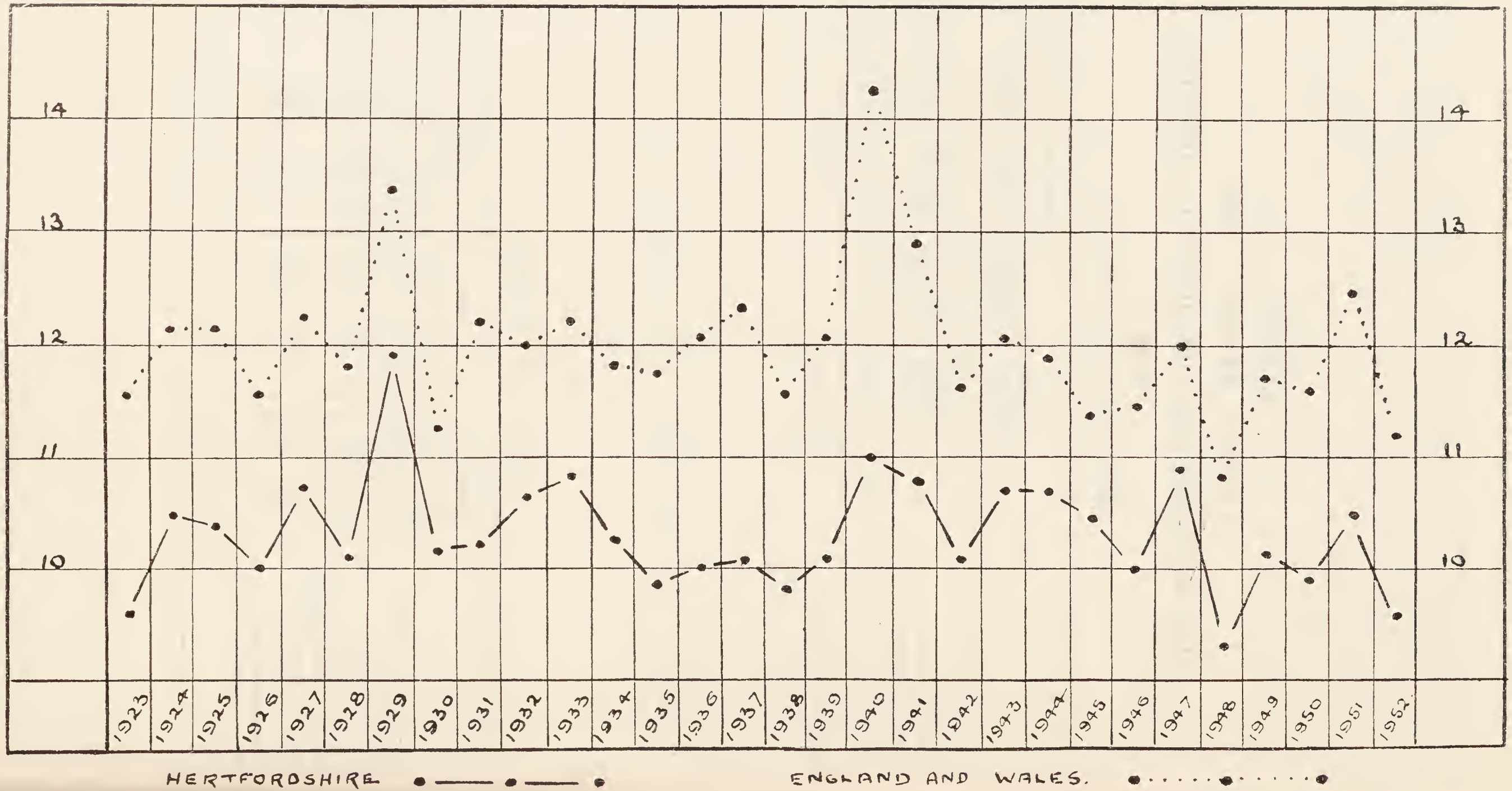


Table 5.—Causes of Death, 1952.

		Age Groups—Urban Districts															Age Groups—Rural Districts												County Total	
		0—		1—		5—		15—		45—		65—		All Ages		Total M&F	0—		1—		5—		15—		45—		65—		All Ages		Total M&F		
		M	F	M	F	M	F	M	F	M	F	M	F	M	F		M	F	M	F	M	F	M	F	M	F	M	F			
1	Tuberculosis — respiratory	—	—	—	—	—	—	11	9	15	9	9	4	35	22	57	—	—	—	—	—	—	8	7	4	2	5	3	17	12	29	86	1
2	Tuberculosis—other	—	—	—	—	—	—	1	1	2	—	—	—	3	1	4	—	—	—	—	—	—	—	—	1	—	—	—	1	—	1	5	2
3	Syphilitic disease	—	—	—	—	—	—	—	—	2	3	3	1	5	4	9	—	—	—	—	—	—	—	1	—	1	1	2	1	4	5	14	3
4	Diphtheria	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4
5	Whooping cough	1	1	1	—	—	—	—	—	—	—	—	—	2	1	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	5
6	Meningococcal infections	—	1	—	—	—	1	—	—	—	—	—	—	—	2	2	—	—	1	—	—	—	—	—	—	—	—	—	1	—	1	3	6
7	Acute Poliomyelitis	—	—	—	—	—	—	1	1	—	—	—	—	1	1	2	—	—	—	—	—	—	—	2	—	—	—	—	—	2	2	4	7
8	Measles	1	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	—	—	1	—	—	—	—	—	—	1	1	2	8
9	Other infective and parasitic diseases	1	1	—	2	1	—	—	1	3	3	1	2	6	9	15	—	1	1	2	1	—	1	—	—	—	—	—	3	3	6	21	9
10	Malignant neoplasm—stomach	—	—	—	—	—	—	4	3	21	20	39	41	64	64	128	—	—	—	—	—	—	—	—	9	7	16	11	25	18	43	171	10
11	Malignant neoplasm, lung, bronchus	—	—	—	—	—	—	6	3	60	5	59	15	125	23	148	—	—	—	—	—	—	4	1	22	1	18	4	44	6	50	198	11
12	Malignant neoplasm—breast	—	—	—	—	—	—	—	10	—	57	2	39	2	106	108	—	—	—	—	—	—	—	9	—	7	—	18	—	34	34	142	12
13	Malignant neoplasm—uterus	—	—	—	1	—	—	—	3	—	7	—	15	—	26	26	—	—	—	—	—	—	—	1	—	3	—	4	—	8	8	34	13
14	Other malignant and lymphatic neoplasms	—	—	1	3	1	2	11	5	70	58	152	129	235	197	432	—	—	—	—	—	—	7	6	22	17	54	49	83	72	155	587	14
15	Leukæmia, aleukæmia	1	—	—	2	1	—	1	1	7	1	1	4	11	8	19	—	—	1	—	—	—	—	—	1	—	1	3	3	3	6	25	15
16	Diabetes	—	—	—	—	—	—	1	1	2	5	2	24	5	30	35	—	—	—	—	—	—	—	1	1	3	—	4	1	8	9	44	16
17	Vascular lesions of nervous system	—	—	—	—	2	—	6	6	45	68	198	334	251	408	659	—	—	—	—	—	—	4	1	8	28	68	110	80	139	219	878	17
18	Coronary disease—angina	—	—	—	—	—	—	10	—	119	36	219	179	348	215	563	—	—	—	—	—	—	5	—	40	11	73	59	118	70	188	751	18
19	Hypertension with heart disease	—	—	—	—	—	—	—	—	7	3	40	54	47	57	104	—	—	—	—	—	—	—	1	5	4	11	14	16	19	35	139	19
20	Other heart disease	—	—	—	—	—	—	8	4	36	35	240	387	284	426	710	—	—	—	—	—	—	4	4	15	23	107	132	126	159	285	995	20
21	Other circulatory disease	—	—	—	—	—	—	5	3	18	10	90	108	113	121	234	—	—	—	—	—	—	3	2	9	6	38	37	50	45	95	329	21
22	Influenza	—	—	—	—	—	—	—	—	1	1	5	4	6	5	11	—	—	—	—	—	—	—	—	—	1	—	1	—	2	2	13	22
23	Pneumonia	12	7	1	—	—	1	8	1	18	4	72	89	111	102	213	2	—	3	—	—	—	1	1	4	2	23	27	33	30	63	276	23
24	Bronchitis	—	—	—	1	—	—	1	3	36	2	102	59	139	65	204	—	1	—	—	1	—	—	—	12	3	41	14	54	18	72	276	24
25	Other diseases of respiratory system	—	—	2	1	—	—	5	2	9	3	13	10	29	16	45	—	—	1	—	—	—	1	—	4	2	6	1	12	3	15	60	25
26	Ulcer of stomach and duodenum	—	—	—	—	—	—	4	1	13	5	24	12	41	18	59	—	—	—	—	—	—	4	—	8	2	10	1	22	3	25	84	26
27	Gastritis, enteritis, and diarrhœa	4	2	1	—	—	—	3	—	—	5	7	8	15	15	30	3	—	1	—	—	—	1	1	1	—	—	3	6	4	10	40	27
28	Nephritis and nephrosis	—	—	—	—	1	—	6	2	8	2	3	11	18	15	33	—	—	—	—	—	1	3	3	2	3	6	6	11	13	24	57	28
29	Hyperplasia of prostate	—	—	—	—	—	—	—	—	1	—	29	—	30	—	30	—	—	—	—	—	—	—	—	1	—	10	—	11	—	11	41	29
30	Pregnancy, childbirth, abortion	—	—	—	—	—	—	—	3	—	1	—	—	—	4	4	—	—	—	—	—	—	—	2	—	—	—	—	—	2	2	6	30
31	Congenital malformations	7	10	1	2	1	1	2	2	2	2	—	—	13	17	30	3	4	1	1	—	—	2	1	3	2	—	—	9	8	17	47	31
32	Other defined and ill-defined diseases	54	28	2	2	3	1	17	16	36	29	69	111	181	187	368	17	10	2	—	2	1	5	7	12	12	29	47	67	77	144	512	32
33	Motor vehicle accidents	—	—	2	—	1	2	10	5	13	4	9	4	35	15	50	—	—	—	—	1	—	8	2	3	—	2	2	14	4	18	68	33
34	All other accidents	2	2	1	2	1	—	29	9	13	8	6	26	52	47	99	—	1	1	1	—	—	10	3	5	—	6	8	22	13	35	134	34
35	Suicide	—	—	—	—	—	—	9	3	13	3	7	5	29	11	40	—	—	—	—	—	—	3	5	3	2	3	—	9	7	16	56	35
36	Homicide and operations of war	—	—	—	—	—	1	—	1	—	—	—	—	—	2	2	—	—	—	—	1	—	—	—	1	—	—	—	2	—	2	4	36
	Total	83	52	12	16	12	9	159	99	570	389	1401	1675	2237	2240	4,477	25	17	12	4	6	3	74	61	196	142	528	560	841	787	1,628	6,105	

TABLE 6.—BIRTH RATE, 1923–1952.
Per 1,000 Population.

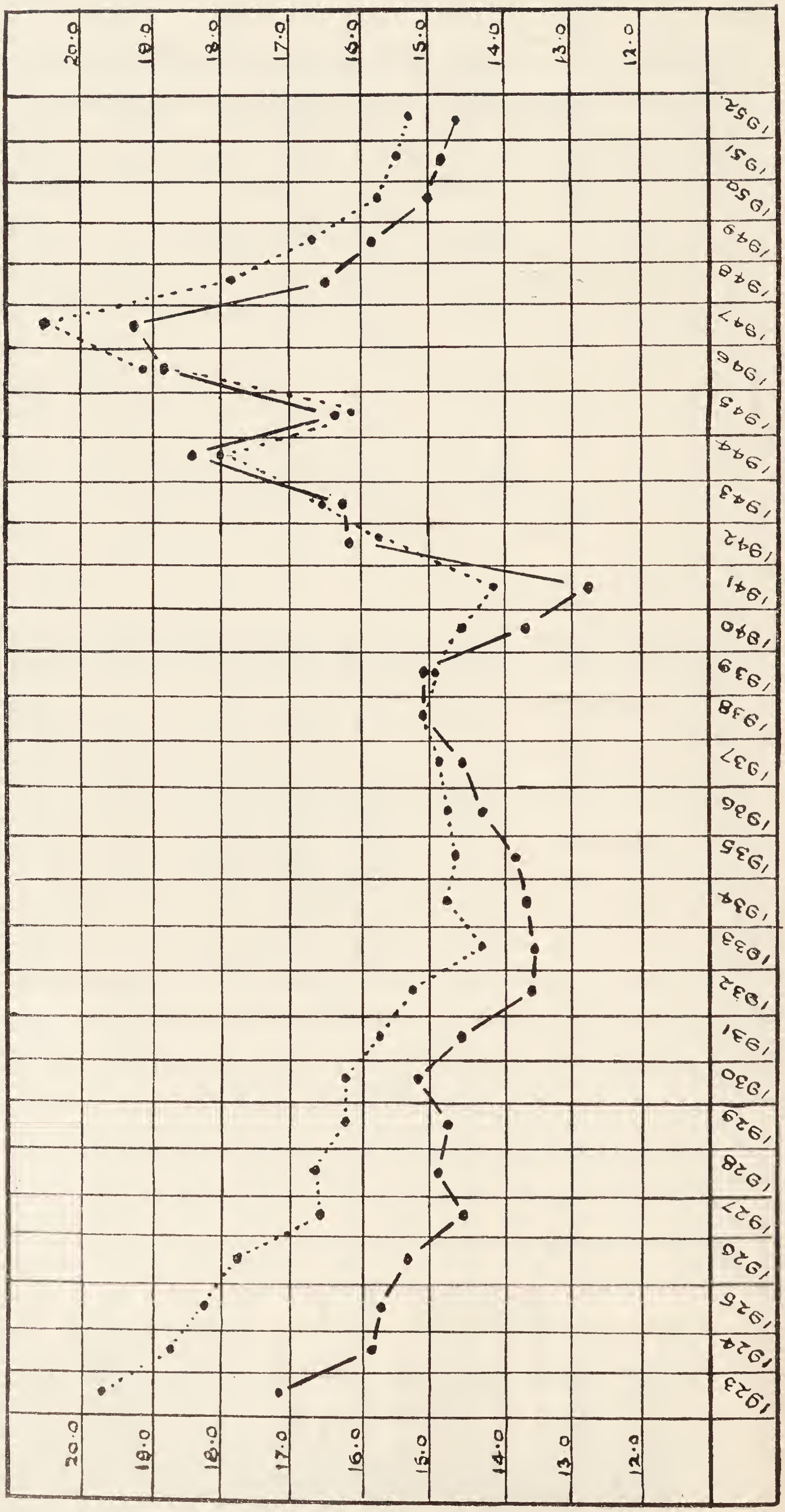


Table 7.
Still-birth Rate.
(per 1,000 births.)

Year	Hertfordshire								England and Wales. Rate
	Boroughs		Urbans		Rurals		County		
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	
1937–46 (average for ten years) .	67	28·9	117	28·7	58	26·2	242	28·6	—
1947 . .	50	16·7	102	19·1	58	19·9	210	18·7	23·9
1948 . .	59	23·3	87	18·6	59	21·5	205	20·6	23·2
1949 . .	56	22·5	83	19·0	56	19·8	195	20·1	22·7
1950 . .	55	23·2	63	15·3	56	20·1	174	18·3	22·6
1951 . .	66	28·1	89	21·3	53	18·3	208	22·1	23·9
1952 . .	51	20·8	77	18·8	56	18·8	184	19·3	22·6

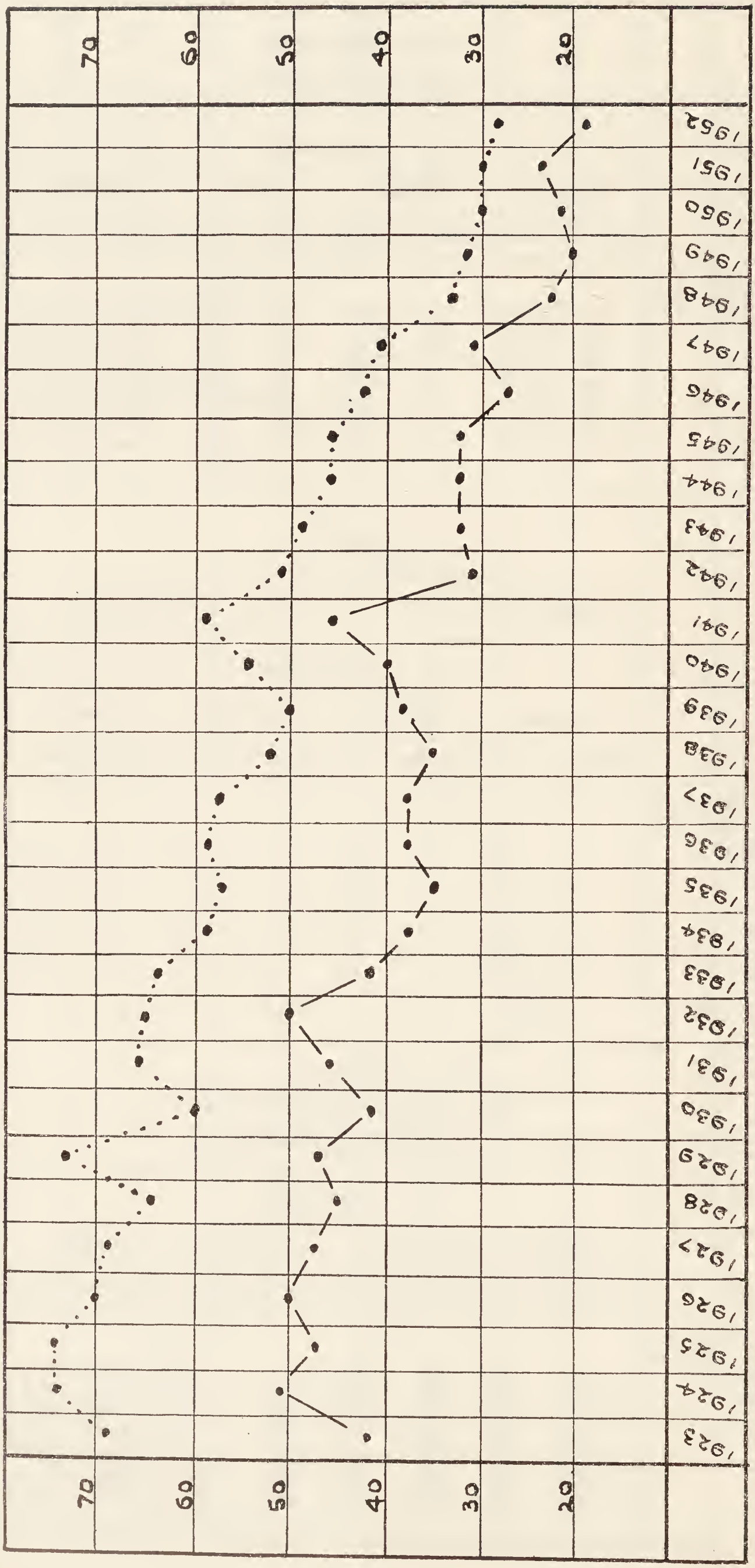
Table 8.
Maternal Mortality.
(Number of Deaths of Mothers per 1,000 Births.)

	Hertfordshire								England and Wales. Rate
	Boroughs		Urbans		Rurals		County		
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	
1937–46 (average for ten years .	4	1·9	10	2·6	5	2·2	19	2·1	2·1
1947 . .	3	1·9	1	0·2	2	0·7	6	0·5	1·2
1948 . .	1	1·5	4	0·9	—	—	5	0·5	1·0
1949 . .	—	—	2	0·5	1	0·4	3	0·3	1·0
1950 . .	1	1·0	5	1·2	4	1·4	10	1·1	0·9
1951 . .	1	1·0	—	—	2	0·7	3	0·3	0·8
1952 . .	1	0·4	3	0·7	2	0·7	6	0·6	0·7

Table 9.
Heart Disease Death Rate.
(per 1,000 population.)

Year	Hertfordshire								England and Wales. Rate
	Boroughs		Urbans		Rurals		County		
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	
1937–46 (average for ten years) .	510	3·6	683	2·8	439	3·0	1,632	3·0	3·2
1947 . .	574	3·8	687	2·6	492	3·3	1,753	3·1	3·5
1948 . .	461	3·1	753	2·7	404	2·5	1,618	2·8	3·2
1949 . .	479	3·1	824	3·0	502	3·0	1,805	3·0	3·6
1950 . .	523	3·4	898	3·2	527	3·1	1,948	3·2	3·8
1951 . .	595	3·8	943	3·4	587	3·2	2,125	3·4	4·1
1952 . .	524	3·3	853	3·0	508	2·7	1,885	3·0	—

TABLE 10.—INFANT MORTALITY RATE, 1923–1952.
Per 1,000 Live Births.



DETAILS ON LIVE BIRTHS AND INFANT DEATHS IN DISTRICTS — 1952.

	Live Births					No. of Infant Deaths (under four weeks)						No. of Infant Deaths (under one year)					
	Legitimate		Illegitimate		Total	Legitimate		Illegitimate		Total	Rate	Legitimate		Illegitimate		Total	Rate
	Males	Females	Males	Females		Males	Females	Males	Females			Males	Females	Males	Females		
BOROUGHS—																	
Hemel Hempstead	209	196	12	13	430	2	3	1	—	6	13·95	2	3	1	—	6	13·95
Hertford	89	96	7	6	198	—	1	—	—	1	5·05	—	1	—	—	1	5·05
St. Albans	340	364	17	18	739	6	4	—	—	10	13·53	13	7	—	—	20	27·06
Watford	503	479	29	22	1,033	9	9	1	—	19	23·20	13	12	1	—	26	31·75
Total Boroughs	1,141	1,135	65	59	2,400	17	17	2	—	36	15·00	28	23	2	—	53	22·08
URBANS—																	
Baldock	59	43	2	2	106	—	—	—	—	—	—	—	1	—	—	1	9·43
Barnet	188	139	5	16	348	3	4	—	1	8	22·99	6	6	—	1	13	37·36
Berkhamsted	80	54	4	5	143	3	1	—	—	4	27·97	3	1	—	—	4	27·97
Bishop's Stortford	103	86	1	4	194	2	1	—	—	3	15·46	3	1	—	—	4	20·62
Bushey	112	87	6	6	211	1	—	—	—	1	4·74	1	—	—	—	1	4·74
Cheshunt	196	159	7	6	368	1	2	—	—	3	8·15	2	4	—	—	6	16·30
Chorleywood	21	29	—	—	50	1	1	—	—	2	40·00	1	1	—	—	2	40·00
East Barnet	246	221	5	7	479	3	1	—	—	4	8·35	4	3	—	—	7	14·61
Harpenden	100	83	4	1	188	4	3	—	—	7	37·23	5	3	—	—	8	42·55
Hitchin	150	136	12	5	303	4	—	—	—	4	13·20	5	—	—	—	5	16·50
Hoddesdon	106	89	5	1	201	2	—	—	—	2	9·95	2	1	—	—	3	14·93
Letchworth	137	154	9	4	304	3	2	—	1	6	19·74	6	3	—	1	10	32·89
Rickmansworth	146	150	8	5	309	1	—	1	—	2	6·47	1	—	1	—	2	6·47
Royston	39	22	—	—	61	1	1	—	—	2	32·79	1	1	—	—	2	32·79
Sawbridgeworth	38	28	1	3	70	2	—	—	—	2	28·57	2	—	—	—	2	28·57
Stevenage	92	64	6	2	164	—	—	—	—	—	—	1	—	—	—	1	6·10
Tring	30	34	2	1	67	1	—	—	—	1	14·93	2	—	—	—	2	29·85
Ware	61	51	4	6	122	3	—	—	—	3	24·59	4	—	—	—	4	32·79
Welwyn Garden City	159	153	5	8	325	1	—	—	—	1	3·08	3	2	—	—	5	15·38
Total Urbans	2,063	1,782	86	82	4,013	36	16	1	2	55	13·70	52	27	1	2	82	20·45
RURALS—																	
Berkhamsted	39	40	5	2	86	—	1	—	—	1	11·63	1	1	—	—	2	23·26
Braughing	74	80	6	3	163	—	—	—	—	—	—	—	1	—	—	1	6·13
Elstree	162	144	5	6	317	2	—	—	—	2	6·31	3	3	—	—	6	18·93
Hatfield	149	163	9	2	323	1	1	—	1	3	9·29	2	1	—	1	4	12·38
Hemel Hempstead	79	93	7	8	187	2	—	—	—	2	10·70	2	—	—	—	2	10·70
Hertford	84	77	2	2	165	1	1	—	—	2	12·12	2	2	—	—	4	24·24
Hitchin	166	161	5	15	347	2	1	—	—	3	8·65	3	2	—	—	5	14·41
St. Albans	182	172	6	12	372	—	2	—	—	2	5·38	1	2	—	—	3	8·06
Ware	79	85	—	4	168	2	2	—	—	4	23·81	3	2	—	—	5	29·76
Watford	344	340	13	18	715	3	—	1	—	4	5·59	5	1	1	—	6	9·79
Welwyn	44	40	—	1	85	—	1	—	—	1	11·76	2	1	—	—	3	35·29
Total Rurals	1,402	1,395	58	73	2,928	13	9	1	1	24	8·20	24	16	1	1	42	13·34
Total County	4,606	4,312	209	214	9,341	66	42	4	3	115	12·31	104	66	4	3	177	18·95

The deaths of legitimate and illegitimate children respectively in the Boroughs, Urban, and Rural Districts in the County are shown as a rate per thousand of live births of each type.

Legitimate.	*Under 4 weeks.*	*Under 1 year.*	*Illegitimate.*	*Under 4 weeks.*	*Under 1 year.*
Boroughs	14·94	22·41	Boroughs	16·13	16·13
Urban Districts	13·52	20·55	Urban Districts	17·86	17·86
Rural Districts	7·86	14·30	Rural Districts	15·27	15·27
County	12·11	19·06	County	16·55	16·55

TABLE 12.—CANCER DEATH RATE, 1923–1952.
Per 1,000 Population.

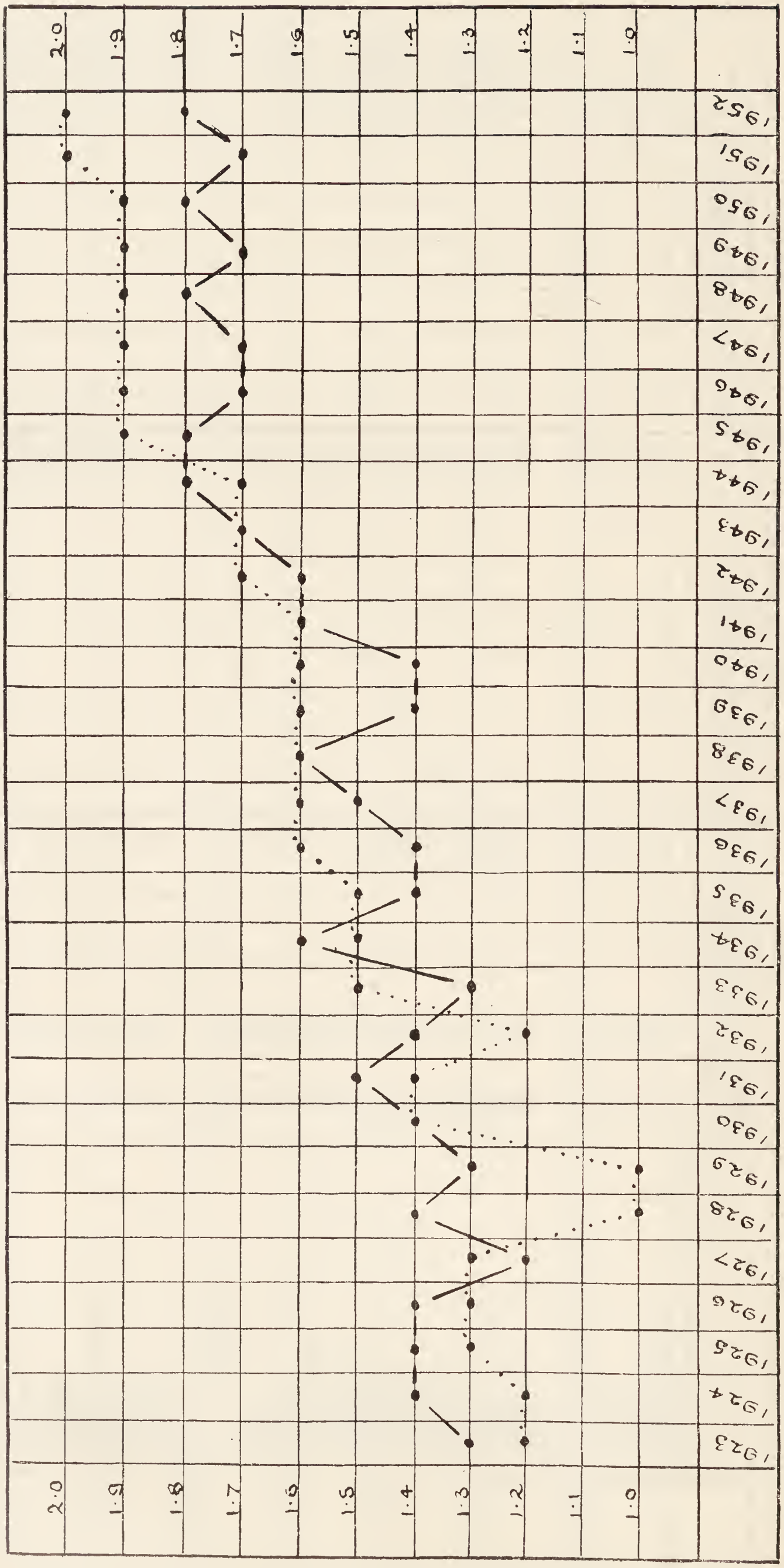


TABLE 15.

Notifications of Infectious Diseases, 1952.

	Scarlet Fever	Whooping Cough	Acute Poliomyelitis: Paralytic	Acute Poliomyelitis: Non-Paralytic	Measles	Diphtheria	Acute Pneumonia	Dysentery	Smallpox	Acute Encephalitis: Infective	Acute Encephalitis: Post-Infective	Encephalitis	Enteric or Typhoid	Paratyphoid	Erysipelas	Meningococcal Infection	Food Poisoning	Puerperal Pyrexia	Ophthalmia Neonatorum	Chicken Pox*	Malaria	Undulant Fever	Infective Hepatitis	Weils Disease	Totals Districts
BOROUGHS—																									
1 Hemel Hempstead	7	7	1	1	536	—	—	7	—	—	—	—	—	—	1	3	1	25	—	—	—	—	6	—	595
2 Hertford . .	5	4	—	—	122	—	3	—	—	—	—	—	—	—	—	—	1	1	—	—	—	—	3	—	139
3 St. Albans . .	89	189	—	1	244	—	19	—	—	—	—	—	—	—	12	2	5	—	—	—	—	—	37	—	598
4 Watford . .	106	38	6	2	239	—	15	—	—	—	—	—	—	10	6	6	17	2	—	—	—	—	26	—	473
Total Boroughs .	207	238	7	4	1,141	—	37	7	—	—	—	—	—	10	19	11	24	28	—	—	—	—	72	—	1,805
URBANS—																									
1 Baldock . .	2	2	—	—	161	—	10	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	178
2 Barnet . .	45	91	3	2	40	—	7	3	—	1	—	—	1	1	2	—	7	30	1	—	—	—	4	—	238
3 Berkhamsted .	27	22	1	—	86	—	2	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	139
4 Bishop's Stortford	4	53	1	1	49	—	3	9	—	—	—	—	—	—	—	—	1	39	—	—	—	—	3	—	163
5 Bushey . .	43	10	—	—	85	—	3	1	—	—	—	—	—	—	1	3	—	48	40	—	—	—	—	—	234
6 Cheshunt . .	74	88	2	—	199	—	26	—	—	—	—	—	—	—	5	—	1	—	1	—	—	—	—	—	396
7 Chorleywood .	2	7	1	—	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	14
8 East Barnet .	100	66	1	—	235	—	21	2	—	—	—	—	—	—	—	—	1	1	—	131	—	—	—	—	558
9 Harpenden .	41	37	1	1	36	—	1	1	—	—	—	—	1	—	2	—	—	1	—	—	—	—	—	—	122
10 Hitchin . .	18	54	1	—	23	—	6	1	—	—	—	—	—	—	1	—	1	2	1	—	—	—	2	—	110
11 Hoddesdon .	13	21	2	1	49	—	4	—	—	—	—	—	—	—	6	—	2	—	—	—	—	—	1	—	99
12 Letchworth .	4	110	—	—	291	—	10	9	—	—	—	—	—	—	2	—	6	—	—	—	—	—	—	—	432
13 Rickmansworth .	29	10	—	2	109	—	—	—	—	—	—	—	—	—	1	—	—	1	—	—	—	—	—	—	152
14 Royston . .	—	4	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	8
15 Sawbridgeworth .	—	28	2	—	19	—	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	52
16 Stevenage . .	16	5	1	1	291	—	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	318
17 Tring . .	32	2	—	—	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	37
18 Ware . .	—	13	3	—	30	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5	—	51
19 Welwyn Garden City . .	16	64	3	—	103	—	6	—	—	—	—	—	—	—	1	—	1	—	—	—	—	—	—	—	194
Total Urbans .	466	687	22	8	1,817	—	106	27	—	1	—	—	2	1	22	3	20	122	43	131	—	—	17	—	3,495
RURALS—																									
1 Berkhamsted .	6	9	—	—	19	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	34
2 Braughing . .	4	46	1	—	53	—	10	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5	—	119
3 Elstree . .	10	33	5	2	81	—	—	7	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	139
4 Hatfield . .	14	69	3	1	52	—	7	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	147
5 Hemel Hempstead	5	5	—	—	136	—	3	1	—	1	—	—	—	—	1	—	3	1	—	—	—	—	1	—	157
6 Hertford . .	12	—	1	—	97	—	5	—	—	—	1	—	—	—	1	—	—	—	—	—	—	—	1	—	118
7 Hitchin . .	17	20	4	1	220	—	9	1	—	—	—	—	—	—	1	—	—	—	—	—	—	—	5	—	278
8 St. Albans . .	49	29	1	3	71	—	11	8	—	—	—	—	—	—	4	1	3	2	—	—	—	—	12	—	194
9 Ware . .	6	35	2	—	27	—	9	—	—	—	—	—	—	—	1	—	1	—	—	—	—	—	—	—	81
10 Watford . .	128	184	3	3	198	—	16	—	—	—	—	—	—	—	5	1	1	—	—	—	—	—	—	—	539
11 Welwyn . .	6	—	1	2	56	—	1	—	—	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	68
Total Rurals .	257	430	21	12	1,010	—	71	17	—	1	1	—	—	—	13	3	11	3	—	—	—	—	24	—	1,874
Total County .	930	1,355	50	24	3,968	—	214	51	—	2	1	—	2	11	54	17	55	153	43	131	—	—	113	—	7,174

* Notifiable only in East Barnet Urban District.

NATIONAL HEALTH SERVICE ACT, 1946.

SECTION 22—CARE OF MOTHERS AND YOUNG CHILDREN.

The services available for the mother and her child continue to be among the most important provided by the Health Committee. More and more emphasis is being placed on the essential nature of the care given to this group of the population so that some of the deficiences in their physical and mental states in later life should be avoided. The general situation in the County has been discussed elsewhere in this Report. It would be sufficient, therefore, to draw attention here to some details only.

The number of children attending the Infant Welfare Centres continued to rise even though general practitioner family care is provided for under the Health Act. Some of the Assistant Medical Officers have commented as follows on this matter.

S. Herts.

" It has in one area been found necessary to provide an extra fortnightly session. The numbers have tended, as always, to fluctuate with inclement weather. Although as with school children, the mother can seek her own doctor's advice, has he really the time at the moment to do all the educative work which takes place at the Centre. Can it really be conceded that a crowded surgery where the chronic bronchitic coughs his way through the winter, is really the best place to bring a healthy baby so that the mother may obtain preventive advice."

South-West Area.

" One cannot imagine any family doctor having the time, or the inclination, to keep a detailed check-up and record of a child's progress weekly or even monthly.

" The mothers realise this and especially the mothers of first babies appreciate the moral support and assurance given to them in their new role by regular clinic supervision.

" Many mothers nowadays read a certain amount of the current literature on baby management and tend to come to the clinic for advice on the numerous specific problems which crop up in the management of their own child."

East Herts Area.

" Many problems can arise during the first year or two of life which are easily solved in the Welfare Clinic to the benefit of mother and baby. Many of these problems are minor ones but of major importance to a worried mother ; and again a busy practitioner has not the time to deal adequately with such matters. Also the numerous problems of feeding are best dealt with in the clinic where scales and the health visitor are available. Test weighing can be carried out and a thorough consideration of the history taken into account and the health visitor can follow up the worrying case."

Watford Area.

" The service provided in this branch of work suits the needs of the Watford population satisfactorily. It has been proved by the success of the Avenue Clinic that a moderate number of comfortable well-run centres are more valuable than a larger number of a poorer type, which tend to be badly attended and rather depressing. At the Avenue Clinic, mothers are encouraged to regard the place as a mothers' and children's club, and the centre of activity for the care of children up to five years of age. Mothers and children from any part of the town are made welcome there.

" In every area Health Visitors are relied upon to apportion their time reasonably between informal teaching and weighing, etc., at the Centres. Mothers do not like to be treated as ignorant children, and the Health Visitors

are encouraged by example and precept to sustain a mother's self-respect, and at the same time lead her tactfully in the right direction. Often a great deal of time has to be given up to mothers from higher income groups, whose minds tend to be full of alarms and queries, but the results fully justify the effort made.

" Nothing can ever quite take the place of these well-run Welfare Centres, with the emphasis on active, healthy children, under observation for normal progress."

Ophthalmic Clinics.

These Clinics, which are provided by the Education Committee, are also attended by cases referred from the M. and C.W. Centres. During 1952, 720 attendances were made by children under five and 149 pairs of spectacles were prescribed (the number of attendances is made up of 244 cases attending for the first time and 476 re-examinations).

Day Nurseries.

		Number of Approved Places at 31st December, 1952.		
		0–2 years.	*2–5 years.*	*Total.*
Barnet	53 Wood Street	20	50	70
Boreham Wood	Shenley Road	32	40	72
Bushey	London Road	30	50	80
East Barnet	29 Station Road	23	27	50
Hemel Hempstead	Creche at Nursery School, Lawn Lane	24	—	24
Hertford	10 Queen's Road	20	28	48
Letchworth	1 Norton Way North	20	30	50
Rickmansworth	The Bury	14	26	40
St. Albans	Hall Place Gardens	20	30	50
St. Albans	Royal Road	30	50	80
Waltham Cross	157 High Street	20	20	40
Ware	Bowling Road	10	40	50
Watford	Cassiobury Park	20	50	70
Watford	Leggatts Way	20	60	80
Watford	St. Albans Road (Beechwood)	15	35	50
Welwyn Garden City	Church Road	20	32	52
Welwyn Garden City	Woodhall Lane	20	50	70
		358	618	976

York Road Creche and Brunswick Park Day Nursery closed during 1952. The Elms Day Nursery closed 31st December, 1952.

Day Nurseries.

Report of the County Nursing Officer.

Miss Howse, Day Nursery Supervisor, left the County on the 31st July, 1952, and I have undertaken the supervision of the Nursery work in conjunction with other duties.

The work has proved most interesting and I have been impressed with the high standard that prevails within the Nurseries.

The Nurseries have been under a barrage for the whole of the year in respect of their usefulness against cost. The Divisional Medical Officers have taken first-hand practical interest in the visiting of the Nurseries, conferring with the Matrons regarding admissions, discharges, and the general well-being of the children.

The Matrons and Wardens have, in some instances, been invited to join the Health Visitors' post-certificate lectures where the subject has been of benefit or interest to all branches. This mingling of all members of the staff should prove beneficial in linking the Health Visitor carrying out the home visiting duties more closely with the Matron who deals with the child in the Nursery.

The Health Visitors are frequent callers at the Nurseries, in addition to the Doctors who attend for immunization, medical examination, and other purposes.

The Elms Day Nursery closed down on the 31st December, 1952. The Fleetville Day Nursery will be able to absorb all children in need of admission.

The number of staff in the Nursery field remains good. There is not a great fluctuation :—

(1) Because Matrons are nearly all married members with their own homes in the area, and are static.

(2) Nursery work is in great demand because of the regular hours of service, and Saturday and Sunday off-duty period.

(3) Nurseries provide an excellent training for girls who have a strong love of child care but who are too young to undertake hospital work.

Many of the students go on to hospital training after they have completed Nursery training, followed by further practical experience.

The training of the students is continued in conjunction with the Education Department and arranged at the Further Education Centres at Barnet, St. Albans, Watford, Welwyn Garden City, and Hertford.

In September, 34 students started training, and 10 15-year-old girls, whose training begins in 1953, started work in the Nurseries. During the year, 20 students completed their training, 16 were successful in the examinations, 4 in June and 12 in September. Seven have left to take up hospital training, private work, or other duties.

In times of staff shortage and difficulty Day Nursery students are loaned to the Nursery School or Residential Nursery services to help out, and this change of work is usually beneficial to the student concerned.

In a few instances, would-be adopters have asked if they can gain insight into handling of children before adopting a child, and arrangements have been made for them to help in local Nurseries, so that confidence can be created. Also Midwives have been asked to encourage ante-natal mothers to attend nearby Nurseries to gain advice and help in handling children prior to the birth of their baby, but this scheme has not materialized.

The new Nursery at Beechwood in Watford (being the only one of its kind in Hertfordshire) has proved of great interest to visitors and is usually included in any programme of Health Visitor Student or Post-Graduate Students visiting the County.

Maternity and Child Welfare Dental Service, 1952.

Report of the County Dental Officer.

The amount of dental attention it has been possible to provide this year for mothers and young children has increased over that of last year due to an improvement in the staffing position. Since the inauguration of the General Dental Service in 1948, it has been necessary to report continual loss of staff until the autumn of 1951, when one dental officer was appointed ; two more appointments were made this year but, unfortunately, one of the other officers left to take up a position under a Scottish Regional Hospital Board. Apart from a part-time officer who moved out of the County, the services of the remaining staff were retained and in several instances their sessions were increased, and two more offers of assistance were accepted.

All the dental practitioners employed by the Hertfordshire Executive Council were circularized by the Local Dental Committee in May of this year and asked to state whether they would consider holding sessions at the County clinics ; four affirmative replies were received, which, on being followed up, resulted in one offer of assistance at a later date. Where appropriate, practitioners are also approached directly, a method which has been successful on occasion. The chief reason for the lack of response is the disparity between the payment received under the National Health Service Scale of fees and that on a sessional basis for the same work carried out. This is supported by the receipt of thirty replies from practitioners expressing willingness to set aside time regularly for the treatment of children in their own surgeries under the General Dental

Service regulations. The Ministers of Health and Education have issued a joint statement that an arrangement whereby mothers and children were referred to practitioners engaged in that service would not be regarded as a satisfactory alternative to the provision of a dental service in the local authorities' clinics. The special measures called for in the dental care of expectant and nursing mothers and children under school age can be provided only by a comprehensive dental service forming part of the local health authorities' general arrangements for the care of mothers and children.

The fall in the demand for treatment resulting from the introduction of charges to patients of General Dental Service practitioners should help to reduce the difficulties experienced in securing suitable dental staff for the local authorities' services. The remuneration which assistants can obtain in general practice will tend to approach that now paid by local authorities and, as a result, it is hoped that a greater number of applications for posts will be received, especially from the more recently qualified dental surgeons and those leaving the Forces. The position would appear to indicate the possibility of progressive improvements with regard to staffing in the not too distant future.

Particulars of the work carried out during 1952 are given in the following Tables :—

MATERNITY.

Number of mothers examined	86
Number of mothers needing treatment	81
Number of mothers treated	63
Number of mothers made dentally fit	52
Extractions	85
Anæsthetics—local 12 General 35	47
Fillings	58
Scalings or Scaling and Gum Treatment	15
Silver Nitrate Treatment	—
Dressings	9

CHILD WELFARE.

Number of children examined	1,216
Number of children needing treatment	872
Number of children treated	658
Number of children made dentally fit	596
Extractions	938
Anæsthetics—Local 37 General 439	476
Fillings	481
Scalings or Scaling and Gum Treatment	13
Silver Nitrate Treatment	191
Dressings	199

It will be noted that the figures show increases over those of last year, particularly with regard to the Child Welfare cases. Concentration on these patients has been continued as the mothers are still able to secure attention much more readily under the National Health Service than are the children. A feature of the treatment given to these young people is the greater proportion of conservation it has been possible to undertake, as shown by the number of fillings carried out per hundred children treated, which has risen to 73, last year's figure being 60.

It is to be hoped that this year may mark the end of the decline of the County Dental Service and the beginning of its eventual restoration and expansion.

UNMARRIED MOTHERS.

The present arrangements in Hertfordshire for the care of the unmarried mother can be considered satisfactory. These mothers are helped by either the Almoners or the Diocesan Workers and very frequently by both. It is pleasing to note from the reports of the Almoners that a number of these girls can make arrangements for their own care before and after their confinement, usually with the active co-operation of the parents. The help given by parents to their

daughters when this situation arises can probably do more towards their rehabilitation than any other circumstances. It is the constant endeavour of the Social Workers to bring a girl back into the family circle with her baby and only when this is impossible do they take action to place the child in a Residential Nursery or arrange for an adoption. There is, of course, frequently a period, even with a helpful family, during which the daughter should be away from home and the Hostel which the Health Committee established at Shenley is then very necessary.

The type of unmarried mother varies quite considerably but arrangement whereby the younger girl can be sent to a Diocesan or similar type of Home for several months goes some way to prevent close association with the less redeemable.

The few beds which the Welfare Committee made available in their Institutions for the " toughest " type proved of use during the year but as will be seen from one of the Almoner's reports these beds do not unfortunately become vacant often and the Hostel at Shenley has then to accept all types of cases.

The following reports of the two almoners dealing mainly with unmarried mothers gives some details of their work during the past year :—

Whole County excluding Dacorum.

In 1952 the number of new cases registered—192—again showed a decrease, the total in 1950 and 1951 being respectively 237 and 225, although the total number of cases old and new under supervision was slightly higher in 1952, viz. 541 compared with 509 and 511 in the two previous years. Campions had an average bed occupancy of 8·43, with considerable fluctuation in numbers which on occasions caused anxiety as to the adequacy of accommodation to meet requirements and on the other hand at times the small number in residence made it difficult to meet domestic needs in the Home, where the girls do a proportion of the cleaning. It is, of course, impossible in this type of work to budget for requirements with much accuracy, and invariably when we have vacancies to offer to other Counties their need also is less, so that there is usually little possibility of " letting off " unwanted vacancies.

During the year (where no other arrangement was possible), four vacancies have been allotted in a Welfare Committee Institution for Unmarried Mothers and their children. These vacancies have for a matter of months been filled by two women, each with three and four children ; one girl with two children and another with one child and another expected, and while every effort was made to find a solution to their problems it was a very difficult situation to resolve, and the accommodation was and still remains blocked for others who may require it. These women were dependent upon National Assistance and Family Allowance, and in order to help them to retain their self respect and not continue to accept such a position indefinitely, arrangements were made whereby the children were accepted into the local Day Nursery (subject to vacancies), to enable the mother to take daily employment and become self-supporting. All those in touch with these girls have been concerned at their unfortunate plight and it is hoped that some better solution than indefinite residence in Part III accommodation—which was never intended—can be found.

During the year the almoners' duties were re-organized and it is now arranged that Miss Morfey covers all almoner duties at Campions, girls admitted there through the agency of the other almoners being referred to her for post-natal plans and help, and as required arranges all adoptions from the Home. A very satisfactory working arrangement in regard to adoption exists between the almoner and Children's Officer, by which the almoner, by virtue of her more personal knowledge of the mothers in Campions interviews prospective adopters and places the infants, subject to full investigation by the Children's Officer, into the circumstances and suitability of the adopters. Contact with adopters is invariably helpful and pleasant ; the almoner has interviewed 27 in the year, of whom 5 have already taken one child through her introduction in the past and are now asking for another.

Dacorum.

Twenty-one cases have been referred to me in the Dacorum area, and in addition, eleven in the South-West Division, where for the last quarter of the year I have been partially responsible for this aspect of the work. The majority of these thirty-two cases have been girls for whom Campions seemed the most helpful solution at the outset, although after investigation and discussion with the girls and with their parents where possible, in seven instances it was found that accommodation in the County Hostel was not required. As in past years, a number of cases have been dealt with by the Moral Welfare Worker, with whom there is close co-operation.

Comprehensive arrangements have had to be made for five German girls, one of whom was finally returned to Germany by the Home Office before her confinement. Another returned to Germany with her baby after her confinement and by arrangement with a Welfare Organization in Germany she went direct to a Hostel on arrival, as she had no suitable home to which to return. It is never an easy matter to persuade these girls to return to their own country and it seems rare for the Home Office to force them to return by making a Deportation Order, and all negotiating and interviews are usually complicated by the language difficulty. A young Irish girl, who had been sent over by her mother from Ireland when she was five months pregnant, was eventually persuaded to return to a Catholic Home in Ireland with her baby.

NURSING SERVICES.

Nursing Staff at 31st December, 1952.

(Figures in brackets denote number with H.V. Certificate.)

	Whole-time.		*Part-time.*	
Administrative	5	(5)	—	—
Health Visiting and School Nursing	56	(56)	3	(3)
Health Vis./Sch. N./Mid./Home N.	49	(15)	—	—
School Nursing	2	—	6	—
Tuberculosis Health Visiting	7	(4)	—	—
Midwifery	16*	(1)	—	—
Dom. Mid./Home Nursing	35	(4)	—	—
Home Nursing	25	—	24	—
Home N./Sch. N./Health Visiting	2	—	2	—

* Including 6 Watford Midwives belonging to Watford Maternity Home (R.H.B.).

Work of the Administrative Nursing Staff.

	1951.	*1952.*
Routine inspections and special visits to Midwives and District Nurses	996	897
Visits to Health Visitors	180	224
Other special visits	442	364
Visits to Secretaries of Local Nursing Associations and interviews	460	599
Visits to Infant Welfare Centres, Clinics, and Schools	313	283
Visits to Nursing and Old Persons' Homes	135	150
Visits to Nursery Schools	41	88
Visits to Maternity Homes and Ante-Natal Hostels	101	53
Attendance at meetings	270	292
Number of talks given	34	25

Hertfordshire County Nursing Trust Fund.

Report of the County Nursing Officer.

After a long period of time the Charity Commission has agreed to the formation of the Hertfordshire County Nursing Trust Fund Scheme whereby money and assets belonging to the ex-District Nursing Associations could be collected into one lump sum, with the object of providing a Fund from which District Nurses and allied staff can be given assistance in various ways.

This is the first scheme of its kind and it is particularly beneficial to those nurses who have retired or will be retiring within the next few years, as these nurses were paid very low salaries for the greater part of their career and had not the benefits of Government pension schemes.

SECTION 23—MIDWIFERY SERVICE.

Report of the County Nursing Officer.

There have not been any undue difficulties in respect of the midwifery service, which has tended to settle down following the upheavals of the differing conditions arising from the 1948 Health Act. The apprehension of the Midwives has proved unfounded when they thought that all their cases would automatically come under complete control of the General Practitioner and, in fact, many of the Midwives are carrying out true midwifery work, as the Doctor is not actually present at the confinement or prior to the Midwife leaving the house. The one danger of the system is that the Midwife may think the Doctor is carrying out complete ante-natal care whereas he, in turn, may assume that the Midwife is doing this part of the work.

The general trend is for domiciliary midwifery cases to increase throughout the County, partly due to the number of families settling into the larger number of new houses available, and also many mothers who have had children at home find that it is much easier to have a confinement at home because sometimes hospitals are many miles away, it is difficult for relatives to visit and lengthy transport under bad weather conditions is an increased source of anxiety to a pregnant woman.

We have 11 midwives approved for teaching and 55 pupil midwives were placed with these teachers, in addition to the Watford midwives attached to King Street Maternity Hospital. This number varies from time to time when resignations take place, as some midwives prefer not to have pupils at all.

The transport position for Midwives and Nurses generally has been considerably eased during the past year with the replacement of 11 new cars.

Ambulance Births.

The figures supplied by the Ambulance Officer indicate that in 29 instances births occurred either in the ambulance or in the house either before or after arrival of an ambulance. Of these 29, the Midwife was present on 5 occasions before birth and 17 after birth.

Occasional lectures and films continue to be given to the Ambulance Drivers and Police Officers on how to cope with emergency midwifery requirements, and these are greatly appreciated by the men concerned.

Stillbirths in Domiciliary Practice.

The rules of the Central Midwives Board require the notification by the midwives in domiciliary practice of all cases of stillbirth. The following Table gives an analysis of the ascertainable causes.

	1952.
Total stillbirths notified :	*19*
Born before arrival of midwife	1
Macerated fœtus	3
Cord difficulties	4
Malformation	3
Prematurity	4
Rhesus Factor	1
Shock during ante-natal period	1
No apparent cause	2

Of the 19 stillbirths notified in 1952—
13 had engaged a doctor.
5 had engaged a midwife.
1 neither doctor nor midwife engaged.

SECTION 24—HEALTH VISITING.

Report of the County Nursing Officer.

The staffing position throughout the year has been very precarious.

In the South-West area the service has been diluted by the addition of 5 part-time nurses to help with the school health service. This is work particularly suited to the married nurse with children, who is happy to do work during term periods but wishes to be free during her own children's school holiday.

The Ministry of Health insists that health visiting work should be carried out by fully qualified persons but allow dispensation to existing nurses who carry out health visiting duties without the necessary qualification. The number for whom dispensation has been allowed is 35.

The link between home visiting and the child requiring admission to the Day Nursery is very strong. The Health Visitors in every case visit the Nurseries weekly to discuss the children with the Matron, to give information regarding the home background and any relevant point that may be of guidance to her, and to keep an eye on the medical welfare of the children in relation to the home.

During the year we have had visitors from abroad and senior officers taking administrative courses, who were interested in observing the health visiting work in Hertfordshire, and there have been 10 Health Visitor Students training with the London Colleges who have come into the County for practical tuition and experience. This greatly adds to the interest of the work of the selected Health Visitor with whom a Student is placed and sometimes it is beneficial to her, as a Student often brings new ideas into the County from her more recent training.

The problem of transport is one that requires careful thought as many of the Health Visitors are disinclined to cycle, particularly in the busy towns.

Mothers' Clubs.—From the small beginnings the Mothers' Clubs continue to increase throughout the County. The Health Visitors find them a useful social contact with the parents of the children and, in one instance, summer picnics and winter theatre trips are arranged, which the mothers greatly enjoy. The Club held in familiar clinic surroundings has a great appeal to the mother who may be shy of making contacts by any other method. The mothers are not drawn from one social group and, therefore, derive benefit from the mixing which takes place. The propaganda which is provided by the careful selection of Speakers at each Club is of immense value, and the provision of adjoining rooms where toddlers can play during the Club session provides a useful contact for mixing with other children, particularly when they happen to be the only child. Some evening clubs are also proving successful.

One advantage of health visiting work is that the times of duty differ from those of the District Nurse, who is " on tap " at all hours, and the Health Visitor has week-ends free, but against this there is not usually accommodation available for a " straight " Health Visitor and the rent differentiation between District Nurse and Health Visitor is a point which causes some dissatisfaction, as both are nursing personnel working for the same department.

One danger of training rural nurses to carry out health visiting duties is that after return to the district and the completion of a contract, the Nurse is tempted to undertake work which is of a more regular nature.

Table 14.

Work carried out by Health Visitors during 1951 and 1952.

No. of New Homes Visited		No. of Babies under Supervision, 31st December		Health Visits to Mothers and Babies		No. of Children aged 1–5 years under Supervision, 31st December		Visits to Children 1–5 years		Health Visitors' Attendances at Welfare Centres	
1951	1952	1951	1952	1951	1952	1951	1952	1951	1952	1951	1952
11,208	12,560	9,336	9,262	67,838	67,156	36,834	36,457	77,036	94,810	9,235	7,498

Child Life Protection.
(on behalf of Children's Committee.)

	No. of Foster Children Visited.	*No. of Visits Paid.*
1951	138	907
1952	452	1,002

Adoption of Children.
(on behalf of Children's Committee.)

	No. of Children Visited.	*No. of Visits Paid.*
1951	241	999
1952	366	904

See page 86 for details of Tuberculosis visiting by Health Visitors.

SECTION 25—HOME NURSING.

Report of the County Nursing Officer.

The general home nursing duties continue to change with the frequent new treatments that are developing.

In the past a woman would select to work in a rural area where she became a very important figurehead of the community, acting as counsellor and friend as well as Nurse to the public concerned. She remained on her district for many years, usually until retirement or death, whereas the districts are now staffed with a changing type of nurse who will probably only remain for the contract period and then move elsewhere, if not back into hospital, or who, in any case, is not prepared to settle down in the truly rural area. The tendency is for more and more married nurses to be employed, and one rather suspects that this work is undertaken in many cases more because of the supply of service houses than desire to choose district work.

One very important factor is that until recently the only method whereby a Nurse could live with her husband, relative, or friend, was by undertaking domiciliary nursing duties, but now all Nurses have the option of being non-resident and work in hospital, which ensures them having their own private lives without the " on call " tie that district nursing entails. In addition to this, the salary paid to hospital staff with equivalent qualifications is greater than that of the domiciliary nurses. Therefore, the balance weighs against the domiciliary field.

Nurses are not popular lodgers because of the uncertain hours of work creating erratic meal times and night telephone calls.

Another problem in respect of housing is that the property within the County varies. Some of the houses are very unwieldy and expensive to run, and others are not suitably placed, but these difficulties will be overcome with time.

Laying out the Dead by District Nurses.

There has been some controversy during the past few years as to the advisability, or otherwise, of District Nurses undertaking last offices as a regular feature of their work. A questionnaire was circulated and an analysis of 57 replies reveals that :—

No District Nurse undertakes this duty as a regular feature of her work.

24 District Nurses perform last offices occasionally, when nobody else available, etc.

(*a*) Only in respect of cases nursed up to time of death—6.

(*b*) Any case in area—18.

33 District Nurses do not lay out the dead.

Of the fifty-seven nurses, six consider it *should* be part of a Nurse's duty for the following reasons :—

(1) (Combined duties) for non-infectious cases, though she is not doing so at present.

(2) (Combined duties) quite often no other help available—four nurses make the point that it is sometimes difficult to obtain a lay person.

(1) (Mid. and gen.) for surgical cases needing special attention—but ordinary cases should be left to lay people.

(2) (Combined duties) Nurses doing general nursing only could lay out their own cases.

Objections to nurses performing last offices :—

	Those now doing so.	*Those not doing so.*	*Total.*
(1) On account of midwifery . . .	4	10	14
(2) Qualified nurse not essential . .	11*	12	23
(3) Both (1) and (2)	2	3	5
(4) Outside district nurse's province . .	—	6	6
	17	31	48

* Watford Home and another district nurse, undertaking general nursing work only, comment that they carry out last offices for special cases, e.g. cancer, tuberculosis, bad dressings, but in their opinion a nurse should not be available at all times to do this duty as a lay person can, and does, fulfil ordinary requirements and a S.R.N. not essential.

With the exception of four districts, all report no difficulty in getting someone to lay out the dead—undertakers wives or assistants, retired nurses, " handywomen."

Charges range from 5*s.* to £2 2*s.*, the charge generally made appears to be 10*s.* 6*d.* to £1 1*s.*

SECTION 26—VACCINATION AND IMMUNIZATION.

The number of primary vaccinations against smallpox continued to increase during 1952 though still remaining very low in proportion to the number of births. The Health Visitors in their routine calls on households with young children and the Medical Officers at the Welfare Centres emphasize to the mothers the importance of vaccinating babies early in life but many parents, for varied reasons, are reluctant to take advantage of the facilities offered to them by their family doctor or at the Infant Welfare Centre.

The number of children, however, who received a full course of immunizing injections against diphtheria showed a fall in comparison with the previous year. The fall may well have been due to the increase in the number of cases of anterior poliomyelitis in 1952 and it is hoped that the leeway will be made up in 1953.

As was stressed in Reports for previous years a feeling of security in regard to an attack of diphtheria would be unfortunate.

It has been stated that to prevent large outbreaks, 75 per cent of the child population should be immunized. It is very difficult to state what the percentage is in Hertfordshire with a continually changing population but our records show only 63 per cent of those under 5 years have been immunized.

" Boosting " or reinforcement injections at the age of 5 years, perhaps also at 10 years of age are an added safeguard and it is satisfactory to note that in 1952 the number given these injections showed an increase over 1951.

Table 15.

Vaccinations.

Year	Primary		Revaccinations	Total during year	No. of live births during year	Percentage vaccinated under one year of age
	Under one year of age	Over one year				
1945	2,439	260	112	2,811	8,746	27·8
1946	3,453	393	366	4,212	10,522	32·8
1947	3,405	484	427	4,216	11,065	30·8
1948	2,400	324	563	3,287	9,756	24·6
1949	2,562	560	966	4,088	9,236	27·7
1950	3,434	1,128	1,737	6,299	9,085	37·8
1951	3,924	1,804	3,004	8,732	9,225	42·5
1952	3,979	1,225	1,772	6,876	9,341	42·6

Diphtheria Immunization.

Year.	*Number of Children who completed a Full Course of Primary Immunization.*		*Number given a Reinforcing Injection.*
	Under 5 years of age.	*Over 5 years of age.*	
1948 . .	7,466	1,136	5,664
1949 . .	7,047	1,449	5,946
1950 . .	6,319	1,037	6,610
1951 . .	7,527	1,015	8,102
1952 . .	6,796	856	8,402

The diphtheria deaths during the past ten years have been as follows :—

Year.	*Males.*	*Females.*	*Total.*
1943	2	4	6
1944	3	5	8
1945	1	—	1
1946	—	1	1
1947	1	1	2
1948	—	1	1
1949	—	—	—
1950	—	—	—
1951	—	—	—
1952	—	—	—

TABLE 16.—DIPHTHERIA NOTIFICATIONS, 1923–1952.

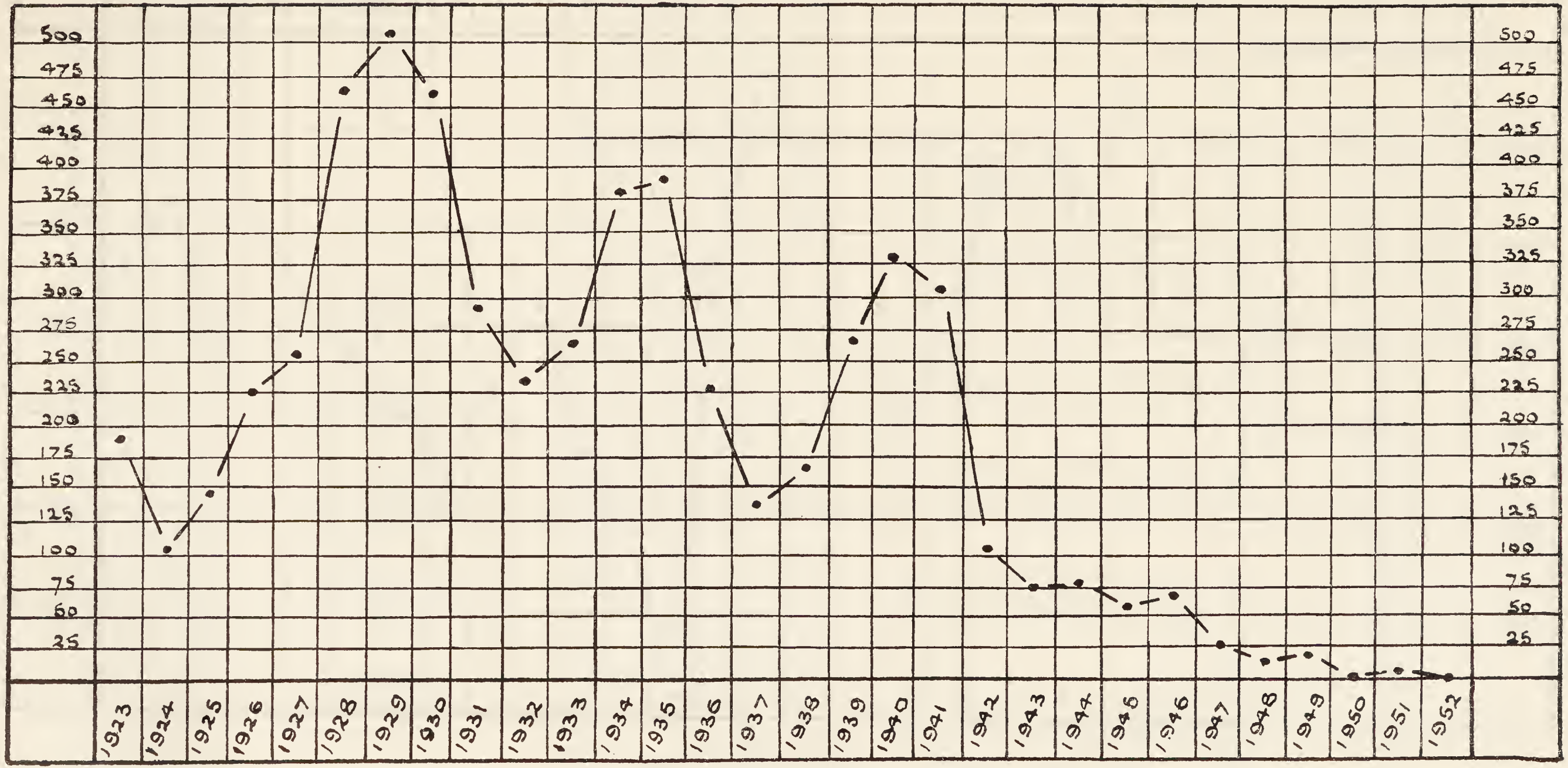
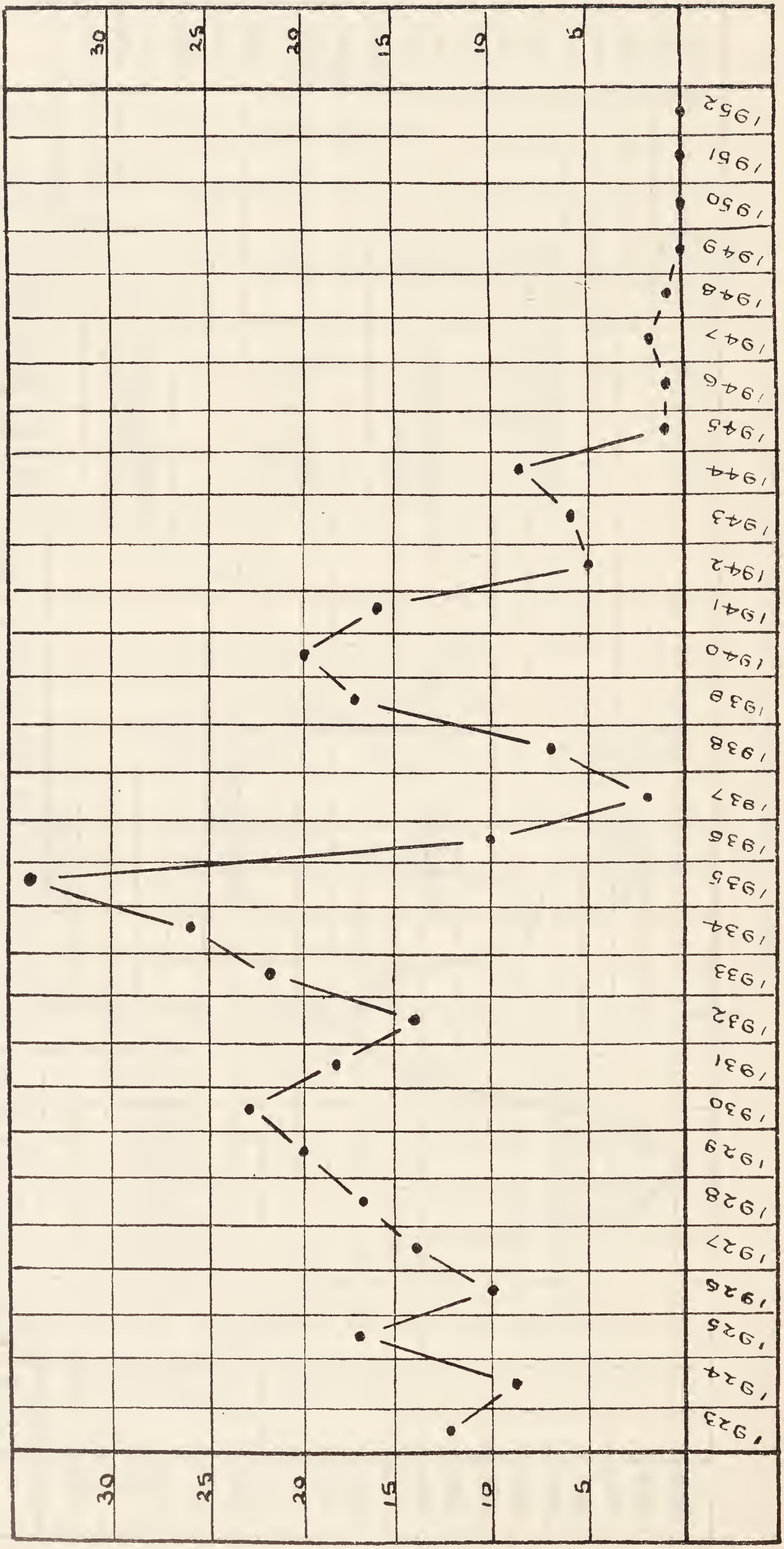


TABLE 17.—DIPHTHERIA DEATHS, 1923–1952.



SECTION 27—AMBULANCE SERVICE.

Report of the County Ambulance Officer.

Demands on the Ambulance Service continue to increase and the table given below shows this upward trend that has proceeded since July, 1948, when the free service under the National Health Act began.

	Number of Cases					Increase 1952 over 1951
	1948	1949	1950	1951	1952	
January . .	—	5,100	7,910	10,209	15,296	5,087
February . .	—	5,521	8,461	10,835	16,039	5,204
March . . .	—	6,264	9,030	12,446	19,074	6,628
April . . .	—	6,695	8,962	10,788	12,072	1,284
May . . .	—	6,513	9,583	10,732	18,760	8,028
June . . .	—	6,007	9,186	14,018	15,480	1,462
July . . .	2,592	7,288	11,092	11,160	17,067	5,907
August . .	3,162	6,214	7,359	8,983	15,347	6,364
September . .	4,048	6,984	10,978	13,116	15,532	2,416
October . .	4,523	8,107	10,166	11,710	17,568	5,858
November . .	4,420	7,300	9,994	12,665	20,632	7,967
December . .	5,283	7,697	11,434	13,716	17,043	3,327
	24,028	79,690	114,155	140,378	199,910	59,532

Prior to 1952, in the case of the Hospital Car Service, the number of journeys only has been given, irrespective of whether two or more patients at a time were carried. The Ministry of Health have now requested that the number of patients carried should be given and state that a person carried to a hospital and later returned should be considered as two patients. In accordance with this request the number of Hospital Car Service cases included in the total of 200,586 is 59,955 as compared with 21,568 journeys during 1951. The number of Hospital Car Service journeys during 1952 was 21,936.

The increase in the number of patients continues to be entirely due to conveyance of hospital removals, as the number of accidents, cases of sudden illness, and maternity continues to remain consistent, as the following table shows :—

	1948 (6 months)	*1949*	*1950*	*1951*	*1952*
Accidents . .	1,273	3,177	3,560	3,960	4,236
Sudden illness . .	1,398	3,298	2,971	2,584	2,387
Maternity. . .	1,639	3,650	3,547	3,691	3,784
	4,310	10,125	10,078	10,235	10,407

During 1951 the number of patients carried by the directly provided service showed an increase of 45 per cent over the previous year, with a corresponding increase in mileage of 21 per cent. In 1952 the increase in the number of hospital patients carried is 18 per cent with a corresponding increase in mileage of 7 per cent. The first year's operation of the wireless scheme has reduced the average number of miles per patient from 10·25 to 8·95 and increased the average number of patients per journey from 1·82 to 2·36.

DETAILS OF CASES DEALT WITH DURING 1952.

	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total	Total Mileage
Accidents . . .	241	243	330	263	427	367	397	500	343	328	408	389	4,236	—
Sudden illness . .	194	242	253	148	243	169	193	213	180	161	197	194	2,387	—
Removals (Maternity) .	286	285	468	275	376	284	309	323	268	252	341	317	3,784	—
Removals . . .	8,908	10,372	12,880	6,911	12,423	9,416	10,339	9,833	9,469	10,939	14,221	11,681	127,392	—
Totals . . .	9,629	11,142	13,931	7,597	13,469	10,236	11,238	10,869	10,260	11,680	15,167	12,581	137,799	1,207,382
Hospital Car Service . .	5,600	4,800	5,000	4,291	5,092	5,004	5,614	4,309	5,075	5,682	5,242	4,246	59,955	577,571
Isolation Hospitals . .	67	97	143	184	199	240	215	169	197	206	223	216	2,156	8,220
	15,296	16,039	19,074	12,072	18,760	15,480	17,067	15,347	15,532	17,568	20,632	17,043	199,910	1,793,173

SECTION 28—PREVENTION OF ILLNESS, CARE, AND AFTER CARE.

Mention has been made before of the almost boundless extent of the field of work possible under this Section of the Act, really only limited by the chains and fencing of financial resources. Year by year as increasing knowledge and interest shows up the individual in the community afflicted by disease, ways are revealed which could be followed up to remove or mitigate the effects of the affliction. These ways frequently bring the individual within the spheres of action of one or other of the Health Authority's services and assistance of one kind or another is requested. The extracts from the statements of the Almoners later in this report give details of the demands being made upon them. The full reports have not been printed but they are available for interested members.

Though the demands did not lessen during 1952, the vacancy created when one of the two Almoners in the South-West Division returned to hospital work was left unfilled as it was considered that additional clerical assistance with some redistribution of the work would enable the remaining Almoner to carry out the really essential work.

It will be seen that as in the Reports for the last few years much space has been given to the Tuberculosis Service. The very great advance in chemotherapy and antibiotics in relation to this disease coincidental with a vigorous campaign through the Chest Clinic Service set up under the Health Act gave added impetus to the effort of the Health Authority to eradicate tuberculous from the community. The national death rate from tuberculosis in 1952 was the lowest for several decades and as this great social disease may now be " on the run " every assistance should be given through the different health services which might in any way hasten its departure from our midst.

The Chest Physicians have supplied full reports on the work of their Clinics during 1952, and their statements read in conjunction with those of the Almoners show how closely interwoven must be the lines of action of both Hospital and Health Authorities.

The present development of Hertfordshire with its population increasing year by year is bringing within its border an undue percentage of tuberculosis persons and included in this Report is a diagram, Table 19, showing how considerable this intake is in the Watford and Elstree Rural Districts. It also shows the effect of having a Training Centre for the tuberculous in Letchworth.

Table 18.

Notifications of Pulmonary and Non-Pulmonary Tuberculosis.

	1950				1951				1952			
	No. of cases notified			Attack rate per 1,000	No. of cases notified			Attack rate per 1,000	No. of cases notified			Attack rate per 1,000
	M	F	Total		M	F	Total		M	F	Total	
Pulmonary.												
Urban . .	189	137	326	0·75	226	133	359	0·83	193	138	331	0·75
Rural . .	64	40	104	0·61	77	65	142	0·79	92	72	164	0·86
County . .	253	177	430	0·71	303	198	501	0·82	285	210	495	0·78
Non-Pulmonary.												
Urban . .	28	32	60	0·13	15	14	29	0·07	21	41	62	0·14
Rural . .	13	19	32	0·18	11	15	26	0·15	11	11	22	0·11
County . .	41	51	92	0·15	26	29	55	0·09	32	52	84	0·13
Pulmonary and Non-Pulmonary.												
Urban . .	217	169	386	0·88	241	147	388	0·9	214	179	393	0·88
Rural . .	77	59	136	0·8	88	80	168	0·94	103	83	186	0·98
County . .	294	228	522	0·86	329	227	556	0·91	317	262	579	0·91

Table 19.

TUBERCULOSIS — 1952.

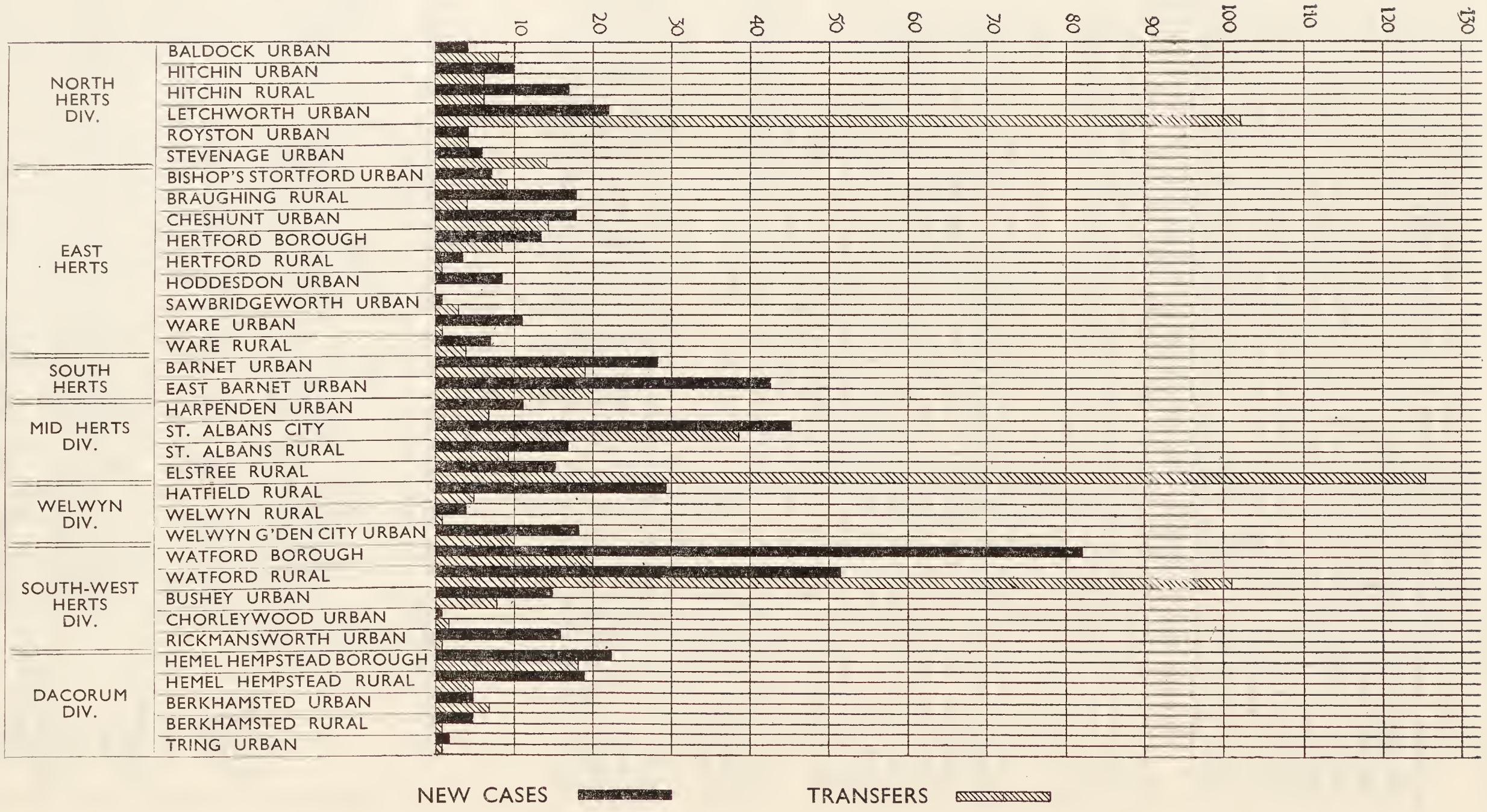


TABLE 20.—TUBERCULOSIS (RESPIRATORY)—DEATH RATE, 1923–1952.
Per 1,000 Population.

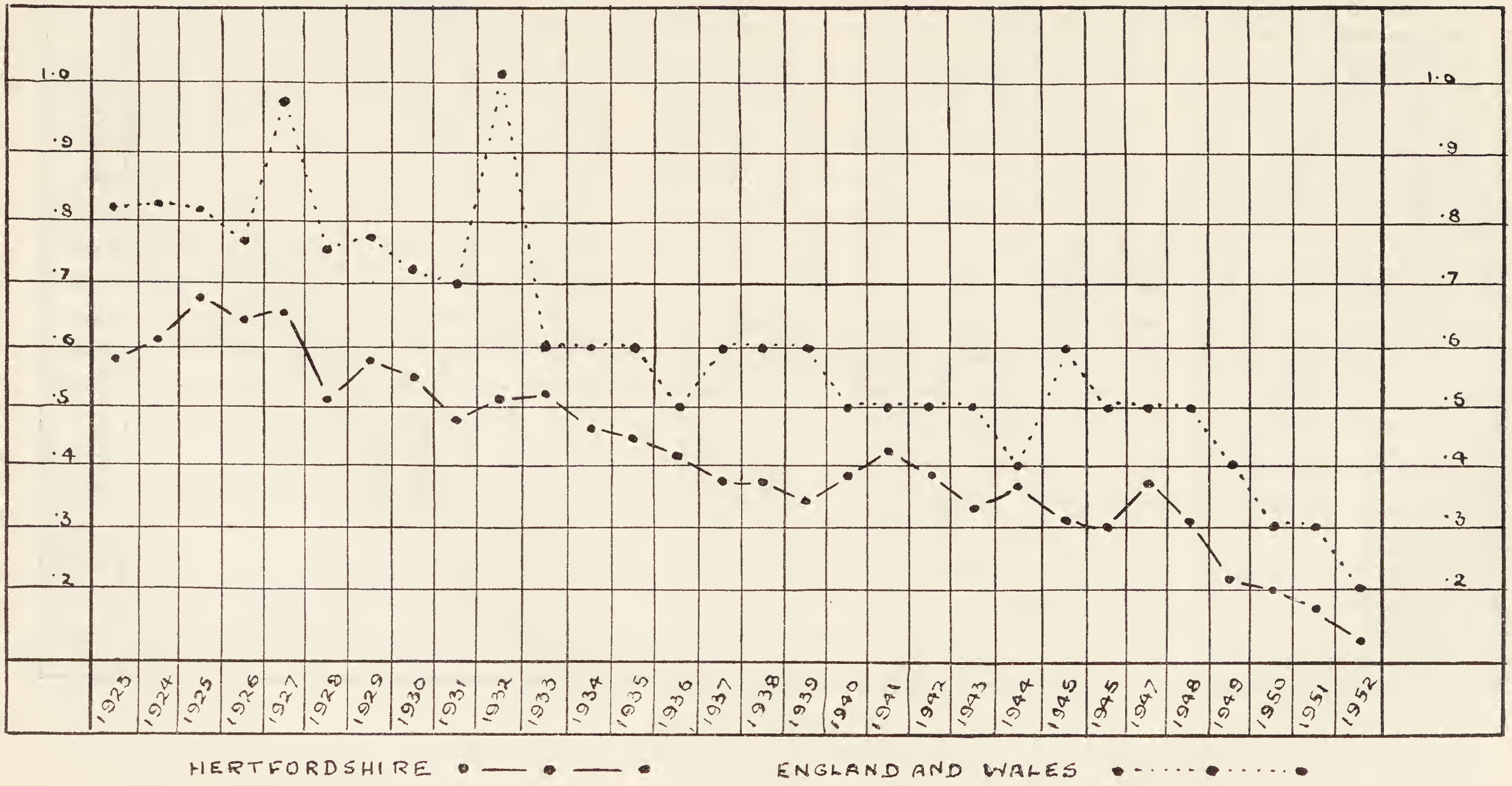
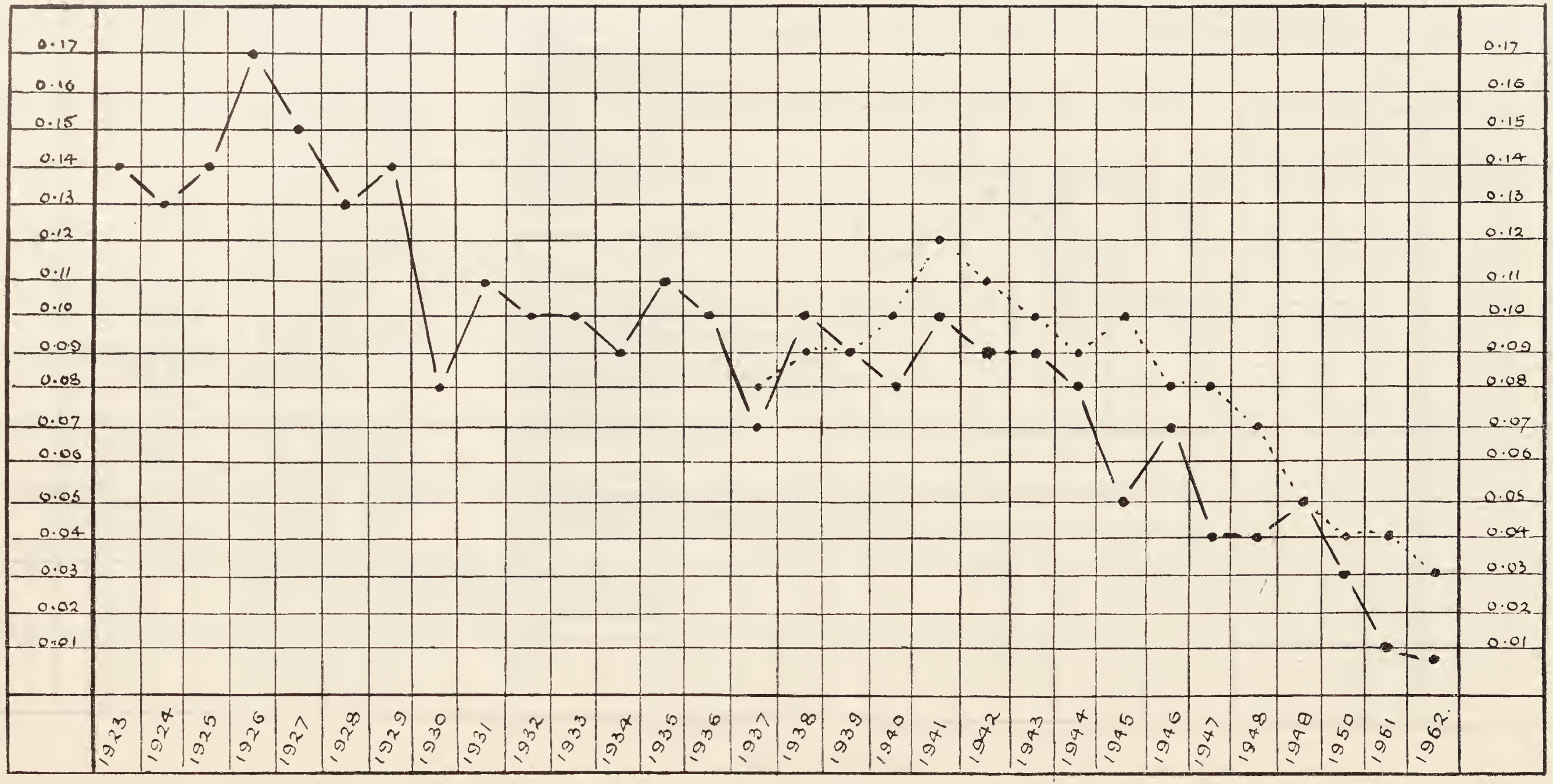


TABLE 21.—TUBERCULOSIS (OTHER THAN RESPIRATORY)—DEATH RATE, 1923–1952.

Per 1,000 Population.



DR. J. BRIAN SHAW, NORTH HERTS.

In spite of the artificial divisions of responsibility between the Local Authority and the Regional Hospital Board the new organization since July, 1948, has, in fact, functioned surprisingly well. This has been entirely due to the goodwill and common sense shown by both parties which have allowed a truly unified service at the chest clinic level.

The steady increase in the number of new patients seen and the extension of contact work including B.C.G. vaccination continued in 1952 in spite of the very cramped and totally unsuitable accommodation in which the chest clinic was functioning. In November the new clinic opened allowing further sessions to be started with an appointment system giving special times for old and new patients and contacts, resulting in less working time being lost by patients.

Treatment.

Ideally the treatment of patients diagnosed as suffering from active pulmonary tuberculosis should take place in a sanatorium or chest hospital. Due to the present shortage of beds many patients cannot be admitted at all or can spend only a short time in hospital for some special form of treatment. Nevertheless, it has been the objective to make modern therapy immediately available to any person suffering from this disease. Therefore, great numbers of patients have to be treated in their homes and as out-patients at the chest clinic. None of this would have been possible without the wonderful co-operation and help given by the District Nurses who carry out the treatment in the patient's home, the Ambulance Service which transports the patients regularly to the clinic, and the Home Helps who keep the family going when the mother is confined to bed for perhaps many months at a time.

Beds for Tuberculosis Patients.

No hospital beds for tuberculous patients have yet been provided in this area. A quota of beds has been allotted in several sanatoria in the North-West Metropolitan Region. One of these, Clare Hall Sanatorium, contains the principal unit for thoracic surgery for this area. At the time of writing this report unfortunately, several wards of this hospital have been closed because of shortage of nursing staff.

Prevention.

The examination and supervision of contacts of tuberculous patients forms an essential part of preventive work. The instruction and education of the infectious patient so that he will not spread his disease occupies a position of paramount importance to-day because of extensive domiciliary treatment and the large number of known infectious cases. The Tuberculosis Visitor who is employed by the Local Authority and attached to the clinic is most intimately concerned with this work. B.C.G. Vacination is offered as a routine to all suitable cases and was given to 57 contacts during the year ; in one case only an enlarged inguinal gland developed. Contacts have readily accepted B.C.G. on the whole and much of this work has been carried out under modified isolation where good home conditions prevailed. B.C.G. Vaccination for child contacts is now up to date in this area except where it has been refused. Except in a few instances only children and nursing staff have received vaccination so far.

A " source " case was found in two schools during the year. All pupils were skin-tested and the positive reacters X-rayed. Schoolmasters and staff were also X-Rayed.

Contact attendances.

There was a considerable increase in the number of contacts attending as shown in the table below :—

	1950.	*1951.*	*1952.*
New . .	134	156	197
Old . .	250	398	610

New Cases Diagnosed.

There was also an increase in the number of new cases of pulmonary tuberculosis diagnosed, as shown in the following table :—

	1950.	*1951.*	*1952.*
Sputum negative .	18	11	24
Sputum positive . .	22	34	38

Infectious Cases.

There was also a considerable increase in the number of open cases known to have a positive sputum in the preceding six months, as shown in the table :—

1950.	*1951.*	*1952.*
53	45	76

Tuberculosis Register.

When this area was taken over by the present staff in 1950 a small up-to-date live register was compiled. This has also considerably increased as shown by the following table :—

1950.	*1951.*	*1952.*
313	377	482

It is well to know that the increase in the number of patients on the register may have some relation to the Government Training Centre at Letchworth. Between January, 1951, and December, 1952, 168 tuberculous patients were accepted for training. A certain number of these have taken up employment in the district and some of the females have married and settled in this area.

Housing.

The re-housing of sputum positive cases has been carried out without unreasonable delay thus often making the boarding-out of child contacts unnecessary.

Appendix.

(1) New Cases of Pulmonary tuberculosis—1952		
Referred by :	General Practitioners . . .	29
	Mass Radiography	15
	Examinations of contacts . .	6
	Diagnosis of cases under observation 1st January, 1952 . . .	—
	Other sources (i.e. other hospitals) .	11
(2) Number of contacts called for examination . . .		201
(3) Number of these seen		197
(4) Number of these skin-tested (positive)		126
(5) Number examined clinically		197
(6) Number X-rayed		197
(7) Number found to have tuberculosis		4
(8) Number kept under observation		3
(9) Number given B.C.G.		57

Dr. A. G. Hounslow, South Herts Division.

The process of expansion noted in previous reports continued steadily throughout the year, as the following figures show :—

	1949	1950	1951	1952
New patients referred to Clinic . . .	442	672	715	792
Old patient attendances	1,737	1,736	1,952	2,464
New contacts seen	222	276	206	325
Old contact attendances	155	397	392	584
Refill attendances	1,646	2,442	4,785	7,830
Total attendances	4,202	5,523	8,050	12,095
New notifications—TB Minus . . .	61	53	59	66
New notifications—TB Plus	35	40	35	22
Notified cases on Register at 31st December .	563	734	699*	846
Register patients with positive sputum or L.S. in last six months	29	46	62	70
Deaths (all causes)	9	22	16	12

* Removal of many names in Register revision.

Although the number of cases on the Register rose during the year, it will be observed that this was not due to an increase in new notifications, which in fact declined slightly ; moreover, the proportion of new patients in the TB PLUS group fell considerably, although rigorous testing, including laryngeal swab culture was employed as a routine measure. It should also be noted that no patient needing hospital care or isolation had to wait at home for more than a few days, and most newly diagnosed patients were admitted to hospital immediately.

In previous years, the increasing work could be attributed very largely to improved Clinic facilities, but a more important factor during 1952 was without doubt the continued development of the L.C.C. housing estate at Boreham Wood. The first tenancies commenced during the week ended 24th February, 1951, and in the remaining ten months of 1951, 22 notified tuberculous patients accepted accommodation on the estate. During 1952 a further 111 notified tuberculous persons accepted accommodation (on Site No. 2) and there are signs that this figure will be considerably exceeded during the coming year as the remainder of Site No. 2 and the larger Site No. 1 open up.

Towards the end of the year, as monthly attendance figures rose to 1,000 and over, the Clinic began to reach saturation point, and very little further expansion is possible with the present premises and staffing. So far as the County Council's staff are concerned, the one Health Visitor, Miss E. S. Gowen, although carrying out a magnificent job of work, found the increased demands of Boreham Wood a very great burden, calling for some relief (now provided in the person of a second Health Visitor to commence duty in January, 1953), while the greatest need in the Almoner's Department was for more clerical staff. (This latter position was worsened by the over-all increase in work which made considerable demands on the clerical staff, who are the employees of the Hospital Management Committee and not of the County Council.)

Housing difficulties continued to give rise to considerable anxiety. In October a detailed report on the Tuberculosis Register for East Barnet, with special reference to housing needs and infectivity, was made to the Medical Officer of Health for that area, who incorporated it in a full report to the East Barnet Urban District Council. As a result of this Report, which received much publicity in the local press, the Council undertook to give priority consideration to tuberculous families with urgent housing needs.

Difficulty was also experienced in providing home helps, partly because of financial considerations, but also because home helps for the tuberculous are in short supply. The revised assessment scales to be introduced should ease the financial aspect materially, while a lecture on tuberculosis given to the Home Helps in East Barnet, may stimulate recruitment to this very important Service.

As the table of work shows, greater time was devoted to the examination of contacts than in previous years, and one might well question the value of much of this activity.

Of the 88 newly-diagnosed cases added to the Register, 2 were discovered by routine contact examination at the Clinic ; one was the 3-year-old son of a patient recently discovered to have advanced open phthisis, and the other the 19-year-old sister of a recently diagnosed man. A third patient, the 4-year-old nephew of a patient with active disease, was diagnosed after examination as a contact at another hospital. It will be noted that no children of school age were diagnosed as the result of contact examination and this appears to be a common experience in Chest Clinic work. It is not suggested that all contact examination should be abandoned, but the *repeated* examination of school children who are contacts of non-infectious cases, is a time-consuming procedure which yields very small dividends, and might well be curtailed. Children below 5 and over 14 years of age need more careful observation, together with those in contact with heavily infectious cases, especially where home conditions or hygienic standards are poor.

A more promising line of attack would appear to be routine skin-testing of all school entrants and the careful investigation of the home contacts of positive reactors. In this way, many unsuspected sources of infection might be brought to light.

Dr. T. A. W. Edwards, St. Albans and Mid Herts.

The work of the Clinic has continued to increase during 1952, a total of 10,035 patients and contacts having been seen. In September, 1952, the L.C.C. Hostel at Sopwell House for chronic sputum positive men was closed.

The Register.

An attempt has been made to bring the Register up to date, making it a true record of the known incidence of Tuberculosis in the area.

Figures have been kept for the past three years and those relating to 1951 are shown in brackets.

(1) Excluding all L.C.C. Transfers-in to Sopwell House, 130 (111) new cases were added to the Register in 1952, and the total number on the Register on 31st December, 1952, was 907. These were derived as follows :—

(*a*) From G.P.	37—21	direct sputum positive		(41)
(*b*) Routine or M.M.R.	9— 2	,,	,,	(30)
(*c*) Contacts	12— 2	,,	,,	(12)
(*d*) Old cases	12— 1	,,	,,	(17)
(*e*) Other sources	60—12	,,	,,	(11)
40 transfer in	— 4	,,	,,	
20 transfers from other departments of the hospital	8	,,	,,	

13 non-pulmonary cases were placed on the register, but three of these were old cases transferred-in from other areas.

(2) No. of home and other immediate contacts involved in the above series of new cases	322	
(3) Number of new contacts called for examination	294	(304)
(4) (*a*) Number of new contacts seen	294	(304)
(*b*) Number of contacts X-rayed by Mass Radiography Unit	1,107	(80)
(5) Number of new contacts Tuberculin tested	117	(420)
of whom 54 (141) were positive and 63 (279) negative.		
(6) Number of new contacts X-rayed	256	(252)
(7) Number found to have tuberculosis	12	(12)

(8) Number kept under observation—220 approx. (This is an approximate figure as no special record is kept of contacts for whom one examination is enough, e.g. in looking for the source case of a person with pleural effusion.)

(9) Number given B.C.G.—25 (46). Seven more were offered B.C.G. and refused and 5 missed the B.C.G. clinic because of illness. A further 5 are to be vaccinated in the near future.

It will be seen that there were 90 primary notifications, and of these 294 new contacts were examined. No effort was made to examine all contacts of cases transferred-in as a routine, as this had usually been done by the previous clinic.

During 1952 this Clinic, with a Register of 907, had only one Health Visitor. The area covered is considerable and it has been necessary to concentrate on priorities. The families of newly diagnosed patients are visited usually within twenty-four hours by the health visitor. Tuberculin jelly tests are applied, and arrangements made for all willing adults to attend for X-ray and interview. This examination is usually completed within a week. All children up to the age of fifteen are tuberculin tested, and if found negative on repeat testing six weeks later, are offered vaccination whatever the degree of infectivity of the index case. Adult contacts up to about thirty years of direct sputum positive cases are offered B.C.G. vaccination if tuberculin negative, but adult contacts of negative cases have not been offered B.C.G. as a routine. In general vaccination has been reserved for those thought to be at increased risk of infection. Follow-up X-rays of all contacts are done by the Mass Radiography Unit.

Segregation is not insisted on where the index case is sputum negative. This usually includes repeated examinations and several negative cultures.

Segregation is undoubtedly desirable when the index case is sputum positive. So far it has been possible to arrange this by admitting the infectious case to hospital, and vaccinating after appropriate re-testing whilst contact is broken in this way. It has not been necessary so far to ask for any child to be boarded out by the local authority solely for this reason.

Hitherto contact work has usually been undertaken with the aim of examining contacts of known cases. Thus the starting point has usually been the known infectious case, and search has been made for possible fresh cases arising in home contacts. In a population that is becoming less tuberculinized there will be increasing value in seeking out positive tuberculin reactors, and searching amongst their home contacts for the source of infection. It is gratifying to know that this method may soon be introduced in the case of school entrants in this county. If it proves of value, it may be desirable to extend this method to other age groups, but in carrying out such a programme the full and active co-operation of the school medical officers and medical officers of health will be essential.

Rehabilitation.

In many cases this has been completed during the patient's stay in Clare Hall, so that he was fit to return to work fairly soon after discharge, but there has been a tendency lately for patients to be discharged somewhat earlier in their course of treatment, e.g. when only up four to six hours, and other arrangements are sometimes necessary before these patients can be returned to work. During 1952 one patient has been sent to Papworth, and two to Enham-Alamein for rehabilitation. It is probable that greater use may be made of these and other facilities in the future.

Provision for Ambulant Chronic Sputum Positive Patients.

Although the number of ambulant chronic sputum positive patients either homeless or occupying a hospital bed or living in unsuitable lodgings is not very large, it is important that there should be some provision for them either in the county or elsewhere. A special hostel would seem to be the best solution, though the siting of it and the provision of amenities require special care.

Dr. N. A. Neville, East Herts.

During 1952 there has been a slow but steady increase in the work of the Chest Clinics at Hertford and Bishop's Stortford, on both the diagnostic and the preventative sides.

We have achieved virtually a 100 per cent attendance rate amongst the contacts of new cases, and apart from one family who refused vaccination, all the known Mantoux negative child contacts at risk in the area have received B.C.G.

In addition to the routine Clinic work, Mass Mantoux and X-ray surveys have been carried out at six schools in the area, in which either a teacher or a child had been detected as suffering from Pulmonary Tuberculosis.

On the treatment side, the waiting list for admission to hospital has been virtually abolished for the priority case, and it is only about two months for a non-priority case.

The urgent need now is the detection of the unknown sputum positive cases in the area ; the grave lack of facilities at the Hertford Chest Clinic is seriously hampering the expansion of our work in this direction.

Reports of Officers in the better known Services have been severely edited in order to save space but it was felt that the Committee would be particularly interested to read in some detail of the work done under Section 28 by the Almoners. Their reports are given *in extenso* though case histories have been altered and modified to prevent the identity of the case being recognizable.

Almoners' Reports.

St. Albans and Dacorum Areas.

On looking through the social records for the past year, one realises afresh how recurrent are the problems of the Tuberculous. Twenty-two cases in need of help throughout the year were men and women who had had treatment within the last four years and had returned to work and now recently relapsed. Some were lucky enough to have achieved as much as three years consistent work, some very much less. Most of them have some idea of applying for help, but they are more than ever in need of prompt and adequate assistance if they are to agree to accept treatment for a second time. This applies equally to the wage earner or the housewife, whether it is a question of making good loss of wages by National Assistance Board allowances, disability pensions, etc., the provision of a Home Help or the admission of the children to a Nursery. It is equally important that this help should be forthcoming without delay, at the same time dealing with the smaller needs, such as pyjamas, additional bedding, books to read, or the provision of a wireless set.

During 1952, eighteen applications for rehousing were supported and in six cases action was very strongly urged ; five of these have been rehoused.

Twenty-one reports have been completed for the Ministry of Labour in an attempt to resettle patients into employment. For seven of these the Disablement Resettlement Officer has found work, nine found vacancies through their own efforts, two became unfit to contemplate work, and four remain without employment. Three men have been accepted for the Rehabilitation Section of Enham-Alamein and one was admitted to Papworth.

Twenty-one applications to Voluntary Funds have been made where no help was available from statutory sources, this in a year in which there have been considerable increases in the allowances payable to tuberculosis patients. The increases were urgently needed, in view of the rising cost of living, and still seem to be inadequate for replacement of larger items such as clothing and household needs, particularly where there is a married couple with no children.

There is, at the same time, a rather disturbing element in the system of allowances, which tends to penalise those who have treated their own finances in a responsible way. For example, Mr. A. was diagnosed a year ago, agreed to stop work and have treatment, and for the past year he has been drawing an allowance from the National Assistance Board. He had no extra commitments, such as hire-purchase, in spite of the fact that a short while before his diagnosis he and his wife and family had been rehoused. He is not fit to return to work, but has put on considerable weight and is in need of new clothes. The National Assistance Board are not able to help over this item, as he still has some small savings.

On the other hand, Mr. B. when diagnosed was buying a television on the hire-purchase system. He had comparatively few further payments to make This was taken into account by the National Assistance Board and a small additional allowance made each week to enable him to complete the hire purchase payments. He has no savings behind him at all, so that if he needs clothing and extra bedding, help will have to be given. One would not wish otherwise ; at the time of diagnosis and during treatment his financial commitment was yet another anxiety for Mr. B., who found it difficult enough to accept the need to stop work and have treatment at all. Both men have very much the same standard home, as far as it is possible to judge.

There is obviously no easy solution to this problem. Patients themselves often feel that there is no encouragement to live otherwise than from hand to mouth. At a time when criticism has been voiced in the Press of Government spending on this section of the community, it is only too easy to forget that, for the group of tuberculous people, a group within the larger group of those receiving National Assistance for one reason or another, the need to produce as high a standard of living as possible is imperative ; not only in order to

maintain the health of the rest of the family but also to reassure the patient himself that he will be able to meet his commitments in spite of carrying out the medical recommendation and giving up work. Even in the odd case where a man, for financial reasons, insists on returning to work prematurely, one feels that the system has failed, and that the cost to the country of treatment for that man when he has a further breakdown is out of all proportion to his present financial needs.

South Herts.

The work in the Barnet Chest Clinic has been increasing steadily during 1952. This can be shown by quoting a few official figures. In January the total number of attendances was 855 and the number of new patients 59. In May the number of attendances was 1,001 and 73 new patients were seen. The highest totals were reached in October, when the number of attendances was 1,260 and there were 98 new patients. Fortunately the increase was comparatively gradual, although there were times when one was unusually busy owing to the number of problem families arriving in Boreham Wood on the new L.C.C. Estate at much the same time.

There are some minor problems which I think should be mentioned, particularly problems which concerned the T.B. families rehoused on this L.C.C. estate, as they affect the lives and physical progress of the patient.

In the early part of the year many patients found the lack of shopping facilities on the estate a great difficulty, especially as the bus services did not help them, and many therefore had a long tiring walk to the village. A few shops for essential commodities have now been opened and there is now a travelling shop service visiting the area on certain days of the week, which has relieved the situation for some. Transport is not only a problem from the shopping angle, but some patients working in London have a long walk to the main road. T.B. mothers, although fairly well, find the tramp to and from the schools a real hardship, besides which they have the heavy expense of footwear which adds to their burden, for many of the roads are rough and filthy with mud and the cement, etc., cuts into their shoes.

As regards these problems, there is perhaps not a great deal an Almoner can do, apart from listening to the tale of woe and in a few cases making an odd suggestion as to how these difficulties might be lessened.

Listening to patients, giving advice or making suggestions for their welfare, whether on the L.C.C. Estate or not, is I believe a very important part of an Almoner's work. How often one hears a patient say, when one has just thrown out a suggestion, " I hadn't thought of that ; it might be possible ! "

To-day one has to admit that there is no real poverty, nevertheless financial worries are normally uppermost in the male patient's mind when he is faced with the fact that he must undergo treatment for a year, eighteen months, or even longer. It is no easy matter for a patient to adjust himself quickly to such a prospect. The wage earner is frequently relieved when he is told about the Special T.B. Allowances under the National Assistance Board ; nevertheless, he is concerned about his commitments, which he realises he can only meet if he is earning a good wage. Hire purchase payments are often the main worry. It may be wise to suggest that he inquires if a smaller weekly payment may be made and payments carried on for a longer period ; it may also seem wise to suggest writing to the firm for him. A large proportion of patients are salaried workers, and although they are not normally faced with immediate financial worries, such patients are often the ones who worry most, for they look into the future and begin to visualize complete calamity, for in six months their salary will be reduced to half, and in a year it will probably cease altogether. The National Assistance Board Allowance is a mere pittance for those who have heavy mortgages to meet, private school fees and heavy insurances, which must at all costs be paid in case " we don't recover ". These patients need a great deal of reassuring, usually they only need a listener, someone who will

help them think and who does appreciate their problems, but who can look at the situation practically. Generally speaking, there is no great calamity. The mortgage may be held over and the money which is saved during the six months when the full salary is received helps when the salary is reduced. In a number of cases where the children are at school the wife gets a job.

Milk.—Many housewives complain that prices are much higher in Boreham Wood than they were in their old districts ; their main complaint is that fruit and vegetables are an exhorbitant price. Those housewives who have higher rents to pay and whose husbands have heavy fares to work find it difficult to make ends meet. They maintain that they cannot possibly afford milk to drink, but only in very exceptional cases has one felt justified in recommending free milk under the County Scheme, where the husband is in full-time employment.

Free milk was recommended for 28 new patients during this year and 13 of these were patients transferred to the Boreham Wood Estate.

There is no doubt that milk is of tremendous value to those whose income is low and who cannot afford plenty of nourishing food. Three patients voluntarily informed me that since they had been having milk they had felt much better and had put on weight.

Housing.—Housing is still a very serious matter and many of our patients continue to live under most unsuitable conditions.

In 1952 20 new patients were referred to the Housing Authorities and only 7 of this number had urgent housing problems from the T.B. point of view, and two families out of the seven have been rehoused. But these figures give no indication of the problem. Many patients were referred for rehousing as long ago as 1948 and are still without adequate accommodation, and serious overcrowding exists even where there is a sputum positive patient.

Unfortunately there is little an Almoner can do, apart from drawing the attention of someone in authority to the urgent deplorable cases from time to time. By the end of 1952 we had only one patient with a serious housing problem in Barnet itself, and he was only notified in November, and it is anticipated that he will be rehoused by the time he has completed his hospital treatment. It is, however, in the New and East Barnet area that the problem exists. The situation was reviewed by the Medical Officer of Health and the Housing Committee in October and we hope that when the houses or flats at present under construction are completed our most urgent problem families will be rehoused.

Home Helps.—A request that a patient should have a Home Help usually casts a heavy gloom over the day for me, as there were two major problems to be overcome whenever a patient needed a Home Help—(1) Would the patient agree to meet the charge which would be made ? (2) Would the Organizer be able to find a Home Help ?

To illustrate these two difficulties I will mention one case. In May it was agreed that a patient with two young children should have them home from a Residential Nursery if she had a Home Help every day. Unfortunately the patient, or husband, not appreciating the difficulties, fetched the children home before help was arranged. There was some delay before the assessment was agreed upon, during which time the patient or her husband, the Chest Physician, and Almoner appealed for the charge to be reduced. Then began the search for a Home Help. In October, after a repeated request, a Home Help was sent to the patient from a town six miles away and then only for two half-days a week. By the end of the year the patient was exhausted and it was feared that it might be necessary for the children to return to a Residential Nursery again.

In 1952 18 patients were referred for Home Helps. Besides these the Chest Physician wanted four others to have help but they refused to consider it on grounds of expense, and as the Chest Physician considered that the financial worry could outweigh the benefit derived from the help, no recommendations were made.

Two of the eighteen patients made private arrangements with the helps found by the Almoner, and paid 2*s*. 3*d*. per hour to the mutual benefit of both at that time. Out of the thirteen remaining cases, the Home Help Organizer found six Helps, the Almoner four, and patients themselves three.

Resettlement.—Resettling a T.B. patient who is unfit to return to his original occupation is a very difficult matter.

During 1952 33 patients were referred to the Almoner, who in turn referred them to the Disablement Resettlement Officer. In a few cases the Almoner arranged that the D.R.O. should attend the Clinic for consultation with the Chest Physician and the patient.

Six of the 33 patients took a Training Course and one went to Papworth. The Youth Employment Officer found a temporary job for this patient, until a vacancy at Papworth came through for him. The Youth Employment Officer also placed two other young persons in employment. The D.R.O.s found twelve patients jobs. Two, however, are not placed entirely satisfactorily as a long-term arrangement, but the D.R.O. has promised to find them something more suitable as soon as possible. Eight patients found their own jobs, four still remain unplaced. One of these is a salaried clerical worker who lost his job at the age of 55 years and it appears to be impossible to get him a clerical job locally, as the Chest Physician does not consider he is fit to travel to London. One of the four is sputum positive. There are still two other sputum positive patients fit to work who were referred to the D.R.O. in 1951, but are still out of employment. A closed workshop would appear to be the only solution for these patients. The final patient was referred to the D.R.O. for a lighter job, but as nothing was found for him, he has remained at his old job.

Part-time employment is more or less unobtainable for men. A few women and girls are able to get part-time work, in the first instance. Two part-time workers had their wages supplemented by an allowance from the National Assistance Board. Many patients returning to their original jobs have been allowed to return on a part-time basis for a few months, but otherwise part-time employment has been out of the question.

In the resettlement of patients the Almoner is the liaison officer between the Chest Physician, the D.R.O., and the patient, who endeavours to make sure, as far as possible, that a job suggested for a patient is suitable. She is also a " watchdog ". She must see that a patient having been given permission to work makes an effort to find a suitable job, or reports to the D.R.O. and does not continue to receive his Sick Allowances longer than is necessary. There are some patients who prefer to try and find work themselves before reporting to the D.R.O. She must also watch that the D.R.O. really makes an effort to place a patient. In areas where the D.R.O. has this one function there is usually little difficulty, but where the D.R.O. combines this job with another and is also responsible for placing fit men in jobs, the disabled person is inclined to be forgotten, particularly if he is not drawing Unemployment Benefit. It is then necessary to remind the D.R.O. from time to time that a certain man is still out of employment and is becoming despondent.

One great difficulty is that D.R.O.s are frequently changing, and this lack of continuity often causes a patient to be forgotten if he is not a very forceful person, or maybe not particularly anxious to work.

Diversional Therapy.—In general, it is not until a patient has returned from hospital or a sanatorium, where he has done some handcrafts, that he takes an interest in diversional therapy. This is, I believe, because he is unable to make an effort to work until he has been shown how to embroider, make rugs and weave, etc. One also finds that when diversional therapy is advised, the patient only asks to do things which he has already done whilst in hospital. This I think points to the need for a Diversional Therapist to give regular instruction in the

homes of those patients on domiciliary treatment. There is no doubt that boredom is greatly relieved for those patients who are able to make something which is creative, or is a work of art.

Those patients who have been visited by the British Red Cross Society (Occupational) Diversional Therapists have greatly appreciated her visits, but many of them have said they wish she could call more regularly to help them. During the last few months of 1952 the Hospital Occupational Therapist occasionally visited the Refill Clinics and showed patients how to begin or finish their work.

Materials have been supplied to a number of patients through the British Red Cross Society. Others, who were in the fortunate position of being able to pay for their materials, have obtained them through the Hospital Occupational Therapist. There is a great advantage in this last arrangement. Patients see the materials first, whereas materials sent by post are not always what is wanted in the way of size or colour.

Barnet patients were fortunate in having a British Red Cross library at the weekly Refill Clinics. The women patients made good use of the library, but the demand from the men was small. The Librarian frequently has requests from patients to get a special book, usually a non-fiction book, which she has not in stock and this she obtains from the Headquarters' Library.

North, East, and Mid Herts.

The following figures give some idea of the amount of assistance which has been arranged for tuberculosis patients during the last year :—

Assistance required :—		*Assistance obtained through :—*			
Financial help	117	Ministry of Pensions			13
Fares and Transport	12	Ministry of National Insurance			5
Milk	47	National Assistance Board			96
Extra Nourishment	9	Hospital Management Committee			13
Bedding, comforts, etc.	26	Health Committee :—			
Clothing	32	Home Help	16		
Housing	26	Free Milk	46		
Diversional Therapy	34	Boarding-out	8		
Resettlement	56	Bedding, etc.	15		102
Care of Children	14	Convalescence	14		
Domestic Help	16	Day Nursery	2		
Convalesence	17	Education Committee :—			
Books	26	Free Dinners		4	
Miscellaneous	32	Clothing		4	
		Nursery School		2	
		Convalescence		2	20
		Youth Employment Officer		5	
		Lessons at Home		1	
		Supervision and Advice		2	
		Herts Blind Society			1
		Probation Officer			1
		Welfare Committee			2
		Herts County Ambulance			2
		Herts British Red Cross Society			71
		Other Voluntary Services			63

Home Visits, 456. Clinic Interviews, 674.

The majority of patients require financial help which can be obtained from the National Assistance Board, Ministry of National Insurance, Ministry of Pensions, etc. Most patients can be assured of an income which will cover their immediate needs and current expenses, but which is usually considerably lower than their normal wage level. They therefore have to go through the painful and worrying process of adapting their standard of living to meet the lower income. This can be further assisted in suitable cases by means of the Health Department's schemes for free milk, boarding-out of T.B. contacts, provision of bedding, etc. ; also by means of free school dinners and clothing grants from the Education Authorities.

Financial problems falling outside the scope of the Statutory and County sources of help can usually be solved via one or more of the many Voluntary agencies.

It can, therefore, be said that a reasonable minimum level of financial circumstances can now be achieved and maintained while patients are under treatment and away from work.

There are, however, a few really poor standard homes still where no amount of help can bring about much improvement as the root of the trouble is a chronic inability to budget, housekeep, look after and care for possessions of any sort. In these cases illness does not cause the poverty in which they live, but only aggravates the situation.

Diversional Therapy continues to be an invaluable means of helping to settle patients down to a period of rest when inactivity is strange and intolerable to them ; also to pass the time away for those patients who have had a long spell off work and for whom there is as yet no prospect of a more active future. One or two patients derive great psychological benefit from selling the articles they make, e.g. shopping baskets, rolled gold jewellery, and leather goods, etc. These patients pay cost price for their materials.

During 1952, two patients have begun correspondence courses in Accountancy and Book-keeping ; in each case the course serves as a pastime and brain exercise, and at the same time is helping to keep the patient in touch with his normal work thus enabling him to be a more employable person than he otherwise would be after a long spell of illness.

The last year too has seen an increase in the use of the T.B. library run by the Red Cross for home-bound patients ; we can now justifiably ask patients to refrain from using the Public Libraries as we can offer an excellent substitute which is greatly appreciated.

Forty-three patients were referred to the Almoner for resettlement during 1952 ; eight were accepted by the Ministry of Labour for courses of training at Training Centres or rehabilitation at Egham, Surrey. Twenty-three patients have returned to their old firms on lighter jobs or were found suitable other employment. Arrangements were made for three patients to become colonists, two at Papworth and Preston Hall, and one at Ware Park. Two broke down again before jobs could be found for them ; one patient, after many months of negotiations and investigations was granted £150 by the Ministry of Labour for equipment for poultry-keeping. The remaining six are proving very difficult to place in suitable jobs, two of these having been turned down for training courses by the Ministry of Labour.

Towards the end of 1952 the Hitchin Chest Clinic opened in which the Almoner enjoys now the use of a comfortable office. The Almoner also during 1952 was given a room to interview patients at the Hertford Chest Clinic. The three Chest Clinics in this area (Bishop's Stortford, Hertford, and Hitchin) now have the Almoner in attendance during the main clinic sessions, and, as many more patients can be interviewed in the clinics there is need for many fewer home visits by the Almoner.

Tuberculosis Visiting.

Report of the County Nursing Officer.

The Tuberculosis Visiting staff has been increased from 7 to 8 and the Visitors' work has tended to become centred on the clinics which the patients attend. Each Tuberculosis Visitor has a caseload of approximately 550 patients to visit in their own homes, plus contacts of these patients.

There is no shortage of staff in this type of work, as we are not tied to employing qualified Health Visitors but can employ nurses with sanatorium experience.

Tuberculosis After Care.

The following figures show the Nurses' activities in 1951 and 1952 :—

	1951.		1952.	
	Attendances at Chest Clinics.	*Visits to Patients.*	*Attendances at Chest Clinics.*	*Visits to Patients.*
Tuberculosis Health Visitors.	1,585	8,652	1,366	10,148
Health Visitors . .	35	281	17	350
District Nurses . .	—	9,579	—	7,577

General After-Care

Almoners' Reports.

North, East, and Mid Herts.

Twenty cases were dealt with in this area during 1952. Of these fourteen were very heavily disabled people :—

Two were helped with Diversional Therapy.

Another living in a condemned back to back hovel was helped on four different occasions with various items to make life a little easier—a comfortable chair, wireless set and licence, extra nourishment, etc.

One young man, whose case has been current since 1949, with a wife and family, greatly disabled as to limbs and speech, has been helped with various forms of occupations at home, e.g. cost of wood for carpentry and poultry-houses.

In most of these fourteen cases a regular friendly visit seems to be appreciated by the patients and their families when the problems can be discussed even though a constructive plan cannot necessarily be evolved at each visit.

The total number of home visits during 1952 to general after-care patients was 53.

South Herts.

There appears to be little demand for the General After-Care of patients in the Barnet area, for in 1952 only 11 new patients were referred to the Almoner. Nevertheless, six of these patients were young chronics who needed, and will probably continue to need, the advice and help of a visiting Social Worker who understands their condition and probable prognosis. It is therefore important that Almoners should be responsible for this work so long as it is possible to continue it with other work and visiting.

Three of the eleven patients were referred by Hospital Almoners, as the patients were being discharged from the hospital, as medically, nothing more could be done for them. These patients required diversional or occupational therapy and later, perhaps, clothes and home comforts. However, after visiting and assessing what the patients could do, in two cases I suggested that they should attend the Hospital Occupational Therapy Department two to three times a week, although they also needed work to do at home. This was arranged for them through the British Red Cross Society, the money for materials being raised from Voluntary Funds ; later, the patients bought their materials through the hospital with the money they had made by selling their first articles. I also suggested that a young girl with chronic arthritis, referred to me originally by the County Medical Officer for a report, as he had been requested by a London Hospital Almoner to accept financial responsibility for certain adjustments in her home to enable her to get about more easily and be more independent, should attend the Occupational Therapy Department at Barnet General Hospital, although still under the care of a London Hospital. Before these arrangements were made I loaned this patient a large loom, borrowed from a patient, and I also arranged for another patient to visit her and teach her how to use it. She learnt to weave successfully and at Christmas time obtained a

number of orders for scarves. To me it is important that young chronic invalids in particular should go out whenever possible.

It is not easy for a Hospital Almoner to assess the capacities of chronically ill persons whilst they are in a ward. It therefore seems important that County Almoners and Hospital Almoners should co-operate to help the young chronic sick, for whom so little is done, and who need constant encouragement and help if they are not to become despondent and depressing burdens to their families.

Another patient, a middle-aged man with disseminated sclerosis, made brushes. He was also loaned a small printing machine, and although not much money could be made by these occupations, they helped and encouraged him a little; even so, alas, he was often depressed.

The majority of chronic invalids live on their National Insurance Allowances, with additional small allowances from the National Assistance Board; such patients cannot afford clothes or to replace bedding, etc. Where the National Assistance Board did not help patients with these requirements in 1952 I referred them to the Personal Service League, and in many cases the patients received a free issue of clothes and sheets, etc.

During the year I had many communications with the Ministry of Pensions about invalid chairs for the disseminated sclerosis patients. One patient (not one of the eleven, as he has been known to the Almoner since 1948), has had his indoor invalid chair changed twice. The third chair, supplied in July, is at last the correct height to enable him to sit up to the table, and the right width to go through doors, which enables him to go to the toilet alone. One patient is hoping his chair will be changed and a third is still waiting for one to be supplied.

Three patients were referred for convalescence, two by doctors and the third by the Probation Officer. Another chronic invalid, a paralysed woman aged 30 years, was referred to the Almoner in the hope that she would be able to suggest a suitable home for this patient, as her father was not only looking after her, but was also having to watch and look after his mentally unbalanced wife. I made many inquiries on behalf of this patient, but before anything was settled she was taken acutely ill and admitted to hospital. Inquiries were reopened after her discharge from hospital, but again, before any arrangements were made, she was re-admitted to hospital and died. Although nothing was achieved here, I think the father of this patient was grateful that there was someone who made an attempt to help him in his predicament.

A T.B. patient asked me to see a young cripple girl who was out of work and whose income was only her 26*s.* a week Unemployment Benefit. She was a pathetic, simple girl, aged 30 years. She had not heard of the National Assistance Board, but when referred to the Board she was, of course, given an additional allowance. This girl, an old poliomyelitis victim, had been working in London for the past four years at an automatic occupation, but having been rehoused with her widowed mother and sister from a condemned prefabricated house, was now unable to obtain a sedentary occupation, and unfortunately she is mentally too slow to benefit from a training course. I shall continue to visit this girl from time to time until work is found for her, as I am sure it is important that there should be someone to show an interest in her. She will no doubt require help with clothes, etc., later. At present there is no organization in Boreham Wood to help such persons.

From 1st October I have been doing the General After-Care work in the South-West Division. Nine new patients were referred, but of these six were straightforward convalescent cases. One was referred by a London Hospital Almoner, but as the patient was to continue treatment at the Peace Memorial Hospital and was already known to the Almoner there, his problems were left to her. A home report only was required for another, but the ninth patient, a chronic invalid, invalided through a work accident, needed help with clothes and bedding. As he was receiving a hardship allowance his income was just above the scale for a National Assistance Board Allowance, and so he did not qualify for any additional National Assistance Board grant which may be made

in certain instances for clothes, etc. As this patient was an ex-regular soldier I referred him to the Forces Help Society and obtained sheets and shirts for him through the Personal Service League.

There were, of course, a number of young chronics on the register who still had problems, and although not many new cases were referred during this quarter, I consider it is important that this work should be continued.

St. Albans and Dacorum.

Forty-five cases have been referred to me under this heading, for the most part by the General Practitioners. Twenty-two have been applications for convalescence. Three brought to light other problems which made routine arrangements for convalescence impractical. A seven-months pregnant woman, with four children, was on the verge of a nervous breakdown and desperately in need of a complete rest away from her family responsibilities. No Holiday Home would accept her, in view of her advanced pregnancy, nor was she anxious to go very far afield. It was possible to arrange for her to go as a paying guest to a private house in Buckinghamshire, owned by some very understanding people anxious to give a rest to anyone really in need, at a nominal charge.

In another instance, a very active and capable old lady, dealing with all household duties, shopping, etc., for her husband and son, was very much in need of a holiday, if she was to carry on. The prospect of going as far as St. Leonards was too much for her, even if the financial side could have been settled satisfactorily, as there was considerable domestic tension and difficulty. For her it was possible to arrange three weeks at a delightful house in the country, where no charge was made, and she was treated as an honoured guest ; this helped her psychologically as much as the care and attention helped her physically.

Apart from these newly-referred patients there have been a few chronic sick, originally referred before 1952, but still needing supervision and the occasional visit. There has been little to give in the way of practical assistance during the past twelve months, but there is perhaps some value in keeping in touch with those who come within this group, hitherto rather neglected from the social point of view. A young woman with disseminated sclerosis was severely disabled, was referred to me in 1951 for help over the problem of £60 needed for repairs to a special chair, essential to her well-being, but not recognized as such by any Statutory body. The money was raised and the repairs carried out. During 1952 she was admitted to hospital very seriously ill, and at the time it seemed likely that she might have to remain in hospital indefinitely. Her condition greatly improved, however, and she is now once more at home and the chair in continuous use.

It is among the young chronic sick, rather than the short-term cases of illness needing convalescence, that I feel there is more case work to be done, but as yet it is something of an unknown quantity. It is noticeable that no cases have been referred by London Hospitals ; this is possibly explained by the fact that the area that I cover is more rural and farther from London than, for example, the South-West Division. Patients tend to be under the care of their local hospital and local Hospital Almoner. This seems reasonable and practical. Any other arrangements to my mind involves a certain amount of overlapping, while still leaving the odd case unknown to any hospital, without any general welfare service.

Mental After-Care.

Almoner's Report.

East and Mid Herts.

Ten new cases have been referred for Mental After-Care ; quite often little help is necessary or possible other than a willing and patient ear, but various forms of help suggest themselves in the course of conversation and where necessary have been arranged.

Holiday Homes.

The requests for Holiday Home convalescence increased again in 1952. However, the number who cancelled their applications, in many cases when they were informed of the charge which they were asked to pay, was quite considerable and only 240 were actually admitted to Homes ; 22 less than in 1951. Many patients agree to go away to a Home when their Doctor or the Hospital Almoner suggests convalescence, in the belief that the convalescence is free under the Health Service Act. Particularly is this the case with the Hospital patients who assume that their convalescence is a part of their Hospital care. As soon as they understand that a charge will be made by the County Council many frequently refuse the offer of convalescence.

Difficulties sometimes arise too, when a Home has patients who do not pay, having been admitted under a Hospital Board or a Voluntary Society along with patients being assessed and charged by Local Health Authorities.

Applications received equalled 357, of which 31 were rejected as unsuitable : 86 subsequently cancelled their applications.

0–1		1–5		5–15		15–45		45–65		65 +		
M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
1	2	1	3	0	2	17	60	30	75	12	37	240

By Whom Referred

Own Doctor	Hospital	County Almoners	Others	
71	94	69	6	240

SECTION 29—HOME HELP SERVICE.

The Home Help Service continued to rank high in cost among the facilities provided by the Health Committee. Costly, however, though it was, there can be little doubt, four years after its inception in its present form, of its incalculable value to a very large number of households in the County. Every person brought more quickly back to health by its use or relieved of undue stress or strain gives a return which cannot be measured in monetary terms.

The very understanding way in which the Sub-Committee dealt with the problems of applying the Standard Assessment introduced during the year was most heartening to all the workers in the Service and no less so to the unfortunate persons who had to call upon it for assistance.

A tribute must also be paid to the members dealing with appeals who have, in their various districts, dealt sympathetically and conscientiously with some very intricate problems.

Report of the Home Help Organizer.

1952 was a year of steady growth in the Home Help Service, despite the fact that a limit had been set to the weekly amount of help any individual case should normally receive. Few major changes took place during the year, but the balance between financial and social considerations continued to worry those responsible for the administration of the Service.

Organizing Staff.

No changes were made in the establishment of organizing staff during 1952, but the Organizer for East Barnet was appointed to the post of Divisional Organizer for one of the Health Divisions of Surrey, and was replaced by Mrs. Darroch at the beginning of December. In addition to this staff, a part-time clerk was appointed to work in the Hitchin office, thus releasing the Organizer for more outside work. Clerical help was also made available in the St. Albans Division.

Home Helps.

Recruitment continued to improve in many areas, the main difficulty still being the recruitment of suitable women to work in Tuberculous Households. In the autumn, the National Joint Council for Local Authorities (Manual Workers) drew up a scheme of Wages and Conditions of Service for Home Helps, and this was adopted by Hertfordshire. This entailed extra work in the calculation of wages, as the County is covered by four different zones—each with its individual rate of pay. The increase gave the Service favourable conditions when compared with the industries in some parts of the County, which were previously attracting our workers. The number of women employed rose from 397 to 430.

Cases Helped.

On 1st January, 1952, there were 993 current cases. On 31st December there were 1,118 current cases. During the first week of the year 8,587½ Home Help hours were claimed, and during the last week 9,772 Home Help hours. Throughout the year, the cases attended were as follows:—

TABLE 22.

Category	Chronic Sick	Blind	Acute Illness	Accidents	Miscel-laneous	Confinements Nursing Mothers	Tuberculous Cases	Totals
Householders other than old age pensioners.	234	21	394	40	198	613	189	1,689
Old age pensioners	972	30	90	10	50	—	7	1,159
Totals. .	1,206	51	484	50	248	613	196	2,848

There was a considerable increase in the number of chronic sick attended in 1951, 965 (735 old age pensioners), and in 1952, 1,206 (972 old age pensioners). There was a considerable reduction in the number of Maternity cases attended, only 613 as against 745 in 1951. This seemed to be largely a matter of expense rather than preference. The number of Tuberculous Households receiving Home Help increased from 179 in 1951 to 196 in 1952. Mass radiography has encouraged women to offer to work in Tuberculous households. Attendance at X-ray sessions is suggested, but not enforced. The Almoners and Chest Physicians have been most co-operative in searching for suitable Home Helps and in talking about the disease to those already enrolled.

Accounts.

In May, 1952, the County Treasurer transferred the accounting for Home Help from manual to mechanized book-keeping. This has resulted in regular weekly accounts being rendered once more, although many older people do not really understand the account form, and inquiries have been numerous. These are being reduced, however, and the system is becoming settled.

Assessment and Appeals.

Throughout 1952, one scale of assessment has been in use. Applicants might appeal against the charge, if they felt it was too high and had points to put forward for consideration, and these appeals were dealt with by Members of the Health Committee. Altogether 374 appeals were considered, and reductions made in 263 cases. The Appeals Committees felt that in the 111 remaining cases, no reduction could be justified. In November, the Health Committee accepted a new scale of assessment for Home Help, bringing the allowances into line with those used by the National Assistance Board, but making extra allowances in the case of persons suffering from T.B. This scale was introduced on 3rd January, 1953.

General Administration.

In May, 1952, the County Council sent the Central Home Help Organizer to the first International Conference on the Home Help Service, held in London. She found the Conference extremely interesting, but felt that conditions in each country had dictated the type of service to be formed, and the highly trained Home Helps to be found in the more advanced Scandinavian countries are not quite what is needed in Great Britain. It was interesting to note that almost every European country sent delegates, but that very few Services elsewhere were financed by public funds, the Churches, and other National Bodies financing most of them. A Home Help Service is almost unknown in the United States.

Welfare of the Staff.

During the year the Home Helps and their Organizers have arranged several outings and parties. These are mainly financed by the Home Helps themselves' but in some areas the Voluntary Home Help Committees have shown hospitality to the staff, and given very enjoyable parties. Altogether, the Home Helps now seem to be a fairly healthy, happy group of women who are confident of their own ability to work well, and of the County Council's interest in their welfare.

Problem Families.

A few extracts are given from a report of one of the Organizers on one of the families helped by the Service.

In this area up to the present time five " Problem Families " have been referred for special help from our " Training Home Helps " and although it is as yet impossible to assess the results as the help must be given over a long enough period in any particular case to have lasting effect, we feel that at least the experience gained up to this point is of value.

We have two Home Helps who are particularly interested in this type of work, both are above the average Home Help standard, one being a trained nurse and the other an ex-Matron of a girls' school.

Although we have not given any special training to these Home Helps they have both read about the methods employed by " The Family Service Units ", one also having attended an address given by the Secretary of this Organization. Regular discussions are held with the organizer about the methods to be employed in each case and the organizer herself visits the cases regularly and plans the general trend of the work ; when necessary working in close co-operation with the family doctor, almoner, housing authority, voluntary bodies, clinic, etc.

On our first visit, at eleven o'clock in the morning, the mother was in bed, the bedclothes of which were filthy, the father making a cup of tea, and the child crawling around the very dirty floor. The whole house was untidy and messy, scraps of food, an open bottle of milk, margarine in its paper, and half eaten scraps of bread, etc., were on the table and mantelshelf. The windows were tightly closed and condensation was making the house damp. Several domestic pets were roaming about the house.

For the first nine months our Home Help went into this family two or three times a week and the Organizer visited as frequently as possible hoping to gain the family's confidence and to gradually train the mother by imitation to follow some sort of routine, as we felt that only by getting into the habit of doing the same thing in the same way each day would she ever be able to learn.

Gradually the Home Help began to be accepted by the family, though not without difficulty owing to their instability.

Eventually we were asked to train the mother to cook and as the request for training had come from the family themselves we were at this stage able to start to help them in earnest. We explained that in order to help the mother to learn to cook and to plan a balanced diet the Home Help must have the right foodstuffs and this in the end led to us taking over the housekeeping altogether

and to the discovery that they were in debt to such an extent that the Home Help was hampered in her work. The County Almoner was called in at this stage and was able to assist the family over their debts on condition that we took on the responsibility of seeing they were paid and were going to be supervising the housekeeping for a while. She was able to get a small weekly sum for three months to be spent on essential goods such as milk, this money was given us to see that it was spent correctly and an extra five shillings a week was obtained from the National Assistance Board.

The responsibility of this extra money was given to the Home Help Service. At this point we took over the budgeting entirely finding that the best way was to put the money allocated for each purpose in separate bags or envelopes and training the mother to use the money in each bag only for the purpose for which it was set aside. In this way we hoped to teach her that it was not only possible to live on a set budget each week but that it was also possible to put a little aside each week for such items as coal. So far this method has proved fairly satisfactory although the mother cannot manage it herself yet unless the Home Help puts the money in the bags for her at the beginning of the week.

We have now been working on these lines for just over three months and although it is not really possible to assess results as yet some progress seems to have been made.

Although we have not dealt with many cases and those that we have only for such a short time, it would appear that the Home Help Service can be of some use in dealing with " Problem Families " providing that a sufficient number of the right type of Home Helps can be recruited. This work needs people with a broad outlook, intelligence, understanding, and patience, with, if possible, some training and real knowledge of the problems they are likely to face but above all it is essential that they should have the right personality for the particular case and this means that ideally the organizer needs several of these Home Helps to choose from so that the right person can be chosen to suit the particular case as so much depends on personal relationship with these families.

Often the family has been almost given up by every other organization and the various people who try to help them are often not able to give sufficient time to each case to break down the families' resentment and help them.

A Home Help enters the household on a different footing and often over the household chores is able to get somewhere near to the root of the individual problems of these families. This not only makes it easier for the Home Help in her work of training but if the organizer is able to work in close co-operation with the other people interested in the case it would appear that this could be of considerable use in the general approach to the problem.

The practical training in their own home does seem to have a certain amount of effect and seems likely to be particularly beneficial in cases of low mentality where there may be difficulty in applying knowledge gained outside the home to home conditions. Progress is it seems bound to be very slow with relapses at intervals, but this would seem only to be expected when we are trying to break down the habits of a life time in adults sensitive to criticism and often unstable emotionally or of low mentality.

From the slight experience gained by dealing with these cases it seems possible to gain a family's confidence and to help them to learn to cope with their difficulties but we have not so far managed to get to the stage when they can manage entirely without us. This is the real test and naturally it is a stage that can only come about after long association with a family but it must be our ultimate goal and it is because we should be aiming at each family's ultimate independence that it is so important to recruit the right type of help for this work and to beware of recruiting people who like themselves to feel indispensible to the people they help. It is for this reason too that it would seem advisable to give special training to these Home Helps so that they have a real insight into the problem we are tackling.

This particular organizer has given details of 4 further cases dealt with on the same lines.

SECTION 51—MENTAL HEALTH SERVICES.

Mental Deficiency Acts, 1913–1938.

The official Return to the Board of Control for the year 1952 was as follows :

	During 1952				Total cases on Authority's registers as at 1.1.1953			
	Under age 16		Aged 16 and over		Under age 16		Aged 16 and over	
	M.	F.	M.	F.	M.	F.	M.	F.
1. *Particulars of cases reported during 1952.*								
(*a*) Cases at 31st December ascertained to be defectives "subject to be dealt with". Action taken on reports by—								
(i) Local Education Authorities on children—								
(1) While at school or liable to attend school .	17	21	—	—	—	—	—	—
(2) On leaving special schools	—	1	—	—	—	—	—	—
(3) On leaving ordinary schools . . .	—	2	—	—	—	—	—	—
(ii) Police or by Courts . .	—	1	2	1	—	—	—	—
(iii) Other sources . . .	10	9	11	11	—	—	—	—
(*b*) Cases reported but not regarded at 31st December as defectives "subject to be dealt with" on any ground	4	4	7	7	—	—	—	—
	31	38	20	19				
(*c*) Cases reported but not confirmed as defectives by 31st December and thus excluded from (*a*) or (*b*) .	1	2	—	5	—	—	—	—
Total number of cases reported during the year	32	40	20	24	—	—	—	—
2. *Disposal of Cases.*								
(*a*) Of the cases ascertained to be defectives "subject to be dealt with" number—								
(i) Placed under Statutory Supervision	23	27	10	5	107	101	84	76
(ii) Placed under Guardianship * .	—	—	1	—	2	1	15	26
(iii) Taken to "Places of Safety" .	1	4	1	2	1	5	2	2
(iv) Admitted to Institutions .	3	3	1	5	83	60	351	255
(*b*) Of the cases not ascertained to be defectives "subject to be dealt with" number—								
(i) Placed under Voluntary Supervision	4	4	7	7	16	9	38	42
(ii) Action unnecessary . .	—	—	—	—	—	—	—	—
Total of Item 2	31	38	20	19	209	176	490	401

* Please state here the number of defectives under Guardianship on 1st January, 1953, who were dealt with under the provisions of Section 8 or 9 :—M. 3. F. —.

	During 1952				Total cases on Authority's registers as at 1.1.1953.							
	Under age 16		Aged 16 and over		Under age 16				Aged 16 and over			
	M.	F.	M.	F.	M.		F.		M.		F.	
3. *Classification of defectives in the community on 1st January, 1953.*					*a*	*b*	*a*	*b*	*a*	*b*	*a*	*b*
(*a*) Cases included in item 2 (*a*) (i) to (iii) above in need of institutional care :—												
(1) In urgent need of institutional care :—												
(i) " cot and chair " cases . .	—	—	—	—	1	1	2	–	–	–	–	–
(ii) ambulant low grade cases .	—	—	—	—	1	3	–	–	–	1	–	1
(iii) medium grade cases . .	—	—	—	—	5	–	2	–	–	1	2	–
(iv) high grade cases . . .	—	—	—	—	5	–	1	–	1	–	3	–
(2) Not in urgent need of institutional care :—												
(i) " cot and chair " cases . .	—	—	—	—	1	1	–	–	–	–	–	–
(ii) ambulant low grade cases .	—	—	—	—	–	1	–	–	–	–	1	–
(iii) medium grade cases . .	—	—	—	—	3	2	3	1	–	–	2	2
(iv) high grade cases . . .	—	—	—	—	5	–	5	–	2	–	2	–
					21	8	13	1	3	2	10	3
Total of item 3 (*a*)	—	—	—	—	29		14		5		13	

Figures in column *a* relate to cases in area of North-West and figures in column *b* relate to cases in area of North-East Metroplitan Regional Hospital Boards.

	Under age 16		Aged 16 and over	
	M.	F.	M.	F.
3. (*b*) Of the cases included in items 2 (*a*) (i) and (ii) and 2 (*b*) (i) overleaf, number considered suitable for :—				
(i) occupation centre . .	77	50	1	23
(ii) industrial centre . .	—	—	12	12
(iii) home training . . .	—	4	1	3
Total of item 3 (*b*)	77	54	14	38
(*c*) Of the cases included in item 3 (*b*) number receiving training on 1st January, 1953 :—				
(i) in occupation centre . .	65	42	1	23
(ii) in industrial centre . .	—	—	2	—
(iii) at home	—	3	1	3
Total of item 3 (*c*)	65	45	4	26

4. Number of Mental Defectives who were in Institutions, under Community Care (including Voluntary Supervision) or " Places of Safety " on 1st January, 1952, who have ceased to be under any of these forms of care during 1952.

	M.	*F.*	*Total.*
(*a*) Ceased to be under care	3	3	6
(*b*) Died, removed from area, or lost sight of . .	11	16	27
Total	14	19	33

5. Of the total number of mental defectives under Supervision or Guardianship or no longer under care.

	M.	*F.*	*Total.*
(*a*) Number who have given birth to children while unmarried during 1952			1
(*b*) Number who have married during 1952	—	—	

2,649 visits to cases in community care were made by the Authority's three whole-time Mental Health Social Workers and by the Organizer of the Occupation Centres, who devotes part of her time to domiciliary visiting.

The following is a summary of the actions taken under the Mental Deficiency Acts during 1952.

Orders obtained on presentation of Petitions by the Authority's Social Workers (Section 6).	49 Hertfordshire patients detained in Institutions. 2 Hertfordshire patients placed under guardianship—in one case following a direction under Section 8 (1) (*a*) by the Courts.
Varying Orders (Section 7) .	4 Varying Orders were obtained, sending Hertfordshire patients formerly under guardianship, to Institutions. 1 Varying Order was obtained on decease of previous guardian.
Court Orders (Section 8). . .	2 Orders were made by the Courts, sending patients to Institutions.
Orders obtained by other authorities on behalf of Herts.	4 Hertfordshire patients detained in Institutions.
Orders obtained by Hertfordshire on behalf of other authorities.	10 Out-County patients detained in Institutions. 1 Varying Order, sending patient formerly under guardianship to an Institution.

During the year 65 patients were admitted to Institutions. Of this number 27 had not previously been on the waiting list of cases requiring Institutional care, but owing to their circumstances had to be dealt with immediately when they came to the Authority's notice.

There were 61 cases awaiting vacancies in Institutions at the end of 1952—a decrease of 9 on the number waiting at the same time last year, and thus the improvement noted in the reduction of the waiting list at the end of 1951 was maintained. The age of the individual case can determine to a large extent the length of the waiting period; adult males being the most difficult to place at the present time.

The following table shows the number of Hertfordshire cases in the area of the North-West and North-East Metropolitan Regional Hospital Boards in their degrees of priority.

TABLE 23.

	North-West.	*North-East.*	*Total.*
1st	4	4	8
2nd	12	2	14
3rd	17	4	21
4th	14	4	18
	47	14	61

The degrees of priority signify varying circumstances and conditions on the following lines :—

(1) *Most Urgent :* Cases where removal to an Institution is the only real solution, and whose continued presence in the home imposes considerable hardship on the other member.

(2) *Urgent :* Where conditions are less severe, but the persons caring for the defective are carrying on under very real difficulties.

(3) *Priority :* (*a*) Where cases are occupying accommodation in either Health Service or Educational establishments, despite having been ascertained to be defective, and representations have been made to the County Council for action to be taken for securing institutional accommodation under the M.D. Acts.

(*b*) Cases where some relief is obtained by the patients attending Occupation Centres, but where there is still more than a reasonable strain being borne by the families in coping with the patients at home, e.g. cases where normal children are adversely affected by the presence of a defective, and the parents request removal.

(4) *Non-Priority :* Where home care is satisfactory, and no priority seems deserved, but the parents ask for Institutional care ; or where no request for Institutional care has been made, but it is considered as probable that changes in the family's circumstances in the future will necessitate priority action.

Under the terms of the Ministry of Health Circular 5/52, 14 cases were admitted during the year to Institutions for a short stay, when a sudden domestic crisis made it imperative for them to be away from their homes.

Under the terms of this circular, it is possible to arrange for this type of case to be placed in Institutions for mental defectives for periods up to two months, without the making of an Order under the Mental Deficiency Acts. A further case already under Guardianship was also found a place in an Institution for a short stay—this patient being licensed from the care of her guardian.

Extracts from Reports of Social Workers.

South and South-West.

It was said at a recent conference on Mental Health that a social worker had more than justified her existence if she managed to place four previously non-working defectives in work. On that basis the past year's work has been satisfactory. It has been uphill work, particularly having regard to the increasing tendency towards unemployment, to persuade employers to give many of the defectives a trial in work, but once having tried them, several firms were willing to take others ; especially was this so in the case of laundries, who were willing to take even obviously mentally defective girls, as they are apparently willing to do very dull and routine jobs where a more intelligent person would easily become bored. By the end of the year good contact had been made with several firms and departments.

Lodgings, however, are increasingly difficult to find for those patients coming out on licence without homes. This may be partly due to the newspaper publicity given to the few crimes committed by defectives.

Altogether supervising patients on licence from Hospitals is the most exacting part of the work, though probably the most worthwhile, from an economic point of view at any rate.

It might be argued that much of the work done with the lower grade defectives was a waste of time and money, as such patients would obviously never be of any use to the community. But much good can be done to help and reassure parents and help them through a very difficult time. If the family can be persuaded to accept the child's deficiency without wishing immediately to cast it out of the family, and to adjust their family life accordingly a good job has been done. In many cases after the child has settled down in an occupation centre only very infrequent visits are necessary.

Contrary to the frequently expressed view that parents are not what they used to be, parents in this area at any rate have faced up to their responsibilities well. In most cases they have only requested institutional care as a last resort. In the main the problem has been over-devotion to the exclusion of the normal children rather than rejection. The Occupation Centres and Advanced Training schemes continue to bring much relief to parents and do much to ease the burden on institutional care.

Efforts were made to get the really low-grade cases into institutions before the parents became so devoted that the parting with their helpless child became almost impossible. Sometimes in such cases the whole family may be sacrificed to the care given to a hopeless idiot.

St. Albans and Dacorum.

Reports on home conditions for Special School leavers have also been dealt with, the latter giving a very good opportunity of establishing friendly relations with parents, which is a great help should the boy or girl subsequently be referred for supervision.

Finding suitable lodgings and employment for defectives takes much time and patience and frequent visits, since such cases require a great deal of help before they are really capable of managing their own affairs.

Reports on their homes, and the advisability of granting leave to cases in Certified Institutions, also forms part of the work, and again this is useful, since it gives some guidance as to the probable suitability, or otherwise, of the defective eventually returning home on licence.

The lack of accommodation in Institutions is a great handicap to the work. There are the low-grade defectives who are quite unsuitable to be cared for in their own homes, often among other normal children, and the higher grade defective, over 16, who needs occupational training and who deteriorates because this is not available. In this regard the 16-year-old girl who leaves a Special School but is not employable is a real problem. She is not a priority case for Institutional care and training, and yet she is very urgently in need of it.

Mid Herts.

Of the 43 defectives under supervision in this rural area, 11 attend Occupation Centres daily and 13 are at work.

During the year six vacancies have been obtained in Cell Barnes Hospital for urgent cases : one girl has been put under guardianship ; and two temporary vacancies have been obtained. Two patients have died.

Of those who remain at home, some are becoming a greater burden upon their parents, while others cause little upset in the family.

Although in every case where the position has become acute, a residential vacancy has been found, the shortage of beds in Mental Deficiency institutions makes social work increasingly difficult. The time to help the parents by removing the defective is when the mother shows signs of strain, not after she has had a breakdown or after the defective has been brought before the Court through lack of adequate supervision in the home.

Occupation Centres.

The Occupation Centres have continued to play their important part in the social welfare services in Hertfordshire.

During the year a Centre was opened in St. Paul's Church Hall, Hemel Hempstead, and twenty children are brought there daily by coach from Berkhamsted, Hemel Hempstead, and the surrounding rural areas. The opening of this Centre, the sixth in the County, has enabled more places to be available in the Watford Centre and the waiting list there has been considerably reduced.

In Hertford it was found necessary because of the difficulties which arose by reason of the varying age groups in attendance to divide the children into juniors, attending on two days each week, and seniors attending on three days. Buildings which would meet all requirements are not easily obtained but one larger than the present hall and with a playground, has been found and it may be possible to make use of it during 1953.

The County Organizer, in the following extracts from her annual report, gives particulars of the work and play of the children attending the Centres :—

At the beginning of 1952 there were 125 feeble-minded and imbecile children attending the day Occupation Centres, at Barnet, Hertford, Hitchin, St. Albans and Watford. The premises at Hertford and Watford still left much to be desired, being too small to accommodate the number of children adequately and having insufficient toilet facilities and no playgrounds. In spite of these deficiencies, the general standard had improved and the handwork had been commended by the Inspectors from the Board of Control. Many pupils are now making rugs, stools, cushion covers, tray cloths, duchess sets, tea cosies, and lamp shades, the parents being charged the cost of materials.

On several occasions when mothers were breaking down under the strain of looking after a low-grade child for whom no vacancy could be found in an

Institution, the child was admitted to a Centre. Although the child was of too low a mentality to benefit much from attendance there and caused all too frequently much upset and extra work, the staff coped with him willingly.

During the New Year holiday period the children from Hitchin and Watford were taken to the local pantomimes, and the Barnet and Hertford groups went to Harringay Circus. These defective children are seldom taken about in public but they thoroughly enjoyed their outings. I would like to mention that the general behaviour and discipline were considerably better than those of many normal children in similar circumstances. The St Albans children were given a party by the local branch of the National Association of Parents of Backward Children and the Barnet branch of this Association presented a radiogram to the Centre, a gift which has been very much appreciated by both the children and staff.

Hitchin Occupation Centre held their Open Day in July, when the children gave a performance of singing, dancing, recitation, and Percussion Band work which although given in cramped circumstances reflected great credit on the staff. Advantage was taken of the large garden to display the handwork and serve tea. This Centre has only one room in the Clinic and is becoming overcrowded but arrangements are being made to enable two rooms to be used by the Centre.

Hertford and Watford Centres also held Open Days, with a performance by the children and a display of handwork.

In November Cell Barnes Hospital held their school concert in which nearly all the children attending the Occupation Centre took part. The parents were impressed with the performance and much credit is due to the Supervisor in amalgamating so competently the day children with the residential children.

The *Evening News* " Toy-for-a-Sick-Child Fund " generously allocated toys and sweets for the children and a Christmas Party was held at each Centre with a Father Christmas to distribute the presents.

By the end of the year there were 131 children attending the six Centres. Two older boys were attending daily at the workshops in Harperbury and Cell Barnes Hospitals for advanced training, and negotiations were proceeding for the attendance of boys and girls in the Watford district to Leavesden Hospital and one boy from Goffs Oak to St. Raphael's Colony, Potters Bar.

A tribute should be paid to the Supervisors and Staff, who have made continued progress with their children and created such a happy atmosphere in their Centres. They have a difficult job, which requires unlimited patience and good humour. They work, in several cases, under a strain due to lack of fresh air and from frustration due to lack of space. They are on duty all day, have no mid-day break, and yet spend many hours outside their normal duty finding new interests for the children.

Mental Treatment.

The arrangements whereby the Divisional Officers of the Welfare Committee undertook the duties required of Duly Authorized Officers continued during 1952. The only change in the staff was the transfer of Mr. English of St. Albans to Welwyn and Mr. Best of Welwyn to St. Albans.

The following report of the Chief Welfare Officer, who is also the Senior Authorized Officer, gives details of the actions necessary in 1952 :—

During the year ended the 31st December, 1952, cases as follows were dealt with by the Duly Authorized Officers under the Lunacy and Mental Treatment Acts, as amended by the National Health Service Acts, 1946 and 1949. The administrative arrangements for this service continued to work smoothly throughout the year.

Those cases arising in that part of the County within the North-East Metropolitan region are admitted to Claybury Mental Hospital, but before their admission a high proportion are, in the first instance, placed under

" observation " for a short period at the North Middlesex Hospital. Cases arising in the northern part of the County within the North-West Metropolitan region continue to be admitted to Three Counties Hospital, those from the southern part of the County within the North-West Metropolitan region to either Napsbury or St. Bernard's Hospitals, and those from the small portion of the County within the East Anglian region to Fulbourn Hospital.

	Men.	*Women.*	*Children.*	*Total.*
(1) *Reception Orders.*				
Admitted direct to hospital	39	59	—	98
Admitted to hospital after " observation " under Sections 20/21	9	49	1	59
By action subsequent to making of Urgency Order, or admitted to hospital under Orders made on Petition	31	27	—	58
By action subsequent to admission as Voluntary Patient	1	4	—	5
By action subsequent to admission as temporary patient	4	2	—	6
(2) *Voluntary Patients.*				
Admitted direct to hospital	28	21	—	49
Admitted to hospital after " observation " under Sections 20/21	13	23	—	36
By action subsequent to making of Urgency Order	43	61	—	104
(3) *Temporary Patients.*				
Admitted direct to hospital	4	3	—	7
Admitted to hospital after " observation " under Sections 20/21	—	9	—	9
By action subsequent to making of Urgency Order	23	9	—	32
(4) *Urgency Orders*	121	112	—	233
(5) " *Observation* " *Cases.*				
Patients admitted to " Observation " Wards under Sections 20/21 (including those above who were subsequently admitted to mental hospital)	23	111	2	136
(6) *Persons recommended for Clinical Treatment and other persons advised by the Authorized Officers*	60	46	2	108
Totals	399	536	5	940

These figures do not include many persons dealt with privately through their own doctors, or otherwise than by reference to the " Duly Authorized Officers ".

The total number of individual patients included in the above statistics is 650 (284 men, 363 women, and 3 children).

In addition to the above figures, Reception Orders, etc., in respect of 23 men and 50 women originally admitted from outside the County of Hertford to mental hospitals in the County were dealt with by the Duly Authorized Officers for the St. Albans and South Hertfordshire Divisions.

Of the 136 cases admitted to " observation " wards under Sections 20/21, 59 were subsequently the subject of Reception Orders, 36 became voluntary patients, 9 became temporary patients, 2 died, 3 were admitted to residential accommodation under Section 21 of the National Assistance Act, 1948, 3 were otherwise dealt with, and 24 were discharged without further action under the Acts.

The following is a comparison with the figures for 1950 and 1951.

	1950.	*1951.*	*1952.*
(*a*) Total number of individuals dealt with by Authorized Officers	623	629	650
(*b*) Voluntary patients	134	162	189
(*c*) Temporary patients	21	34	48
(*d*) Certified patients	258	226	226
(*e*) Urgency Orders	123	207	233

Attention is drawn to the continued increased use of " Urgency Orders " which is in conformity with modern practice, but is also to some extent due to the lack of accommodation in " Observation " Wards in hospitals in the County.

It is interesting to note that out of 233 cases admitted under Urgency Orders 104 subsequently became voluntary patients.

During the year under review, 88 persons as follows who were over pensionable age were certified under the Lunacy Acts :—

65–70.		*71–75.*		*76–80.*		*81–85.*		*Over 85.*		*Total.*	
M.	*W.*	*M.*	*W.*	*M.*	*W.*	*M.*	*W.*	*M.*	*W.*	*M.*	*W.*
7	15	6	19	9	17	5	9	1	–	28	60
										88	

NURSING HOMES.

Report of the County Nursing Officer.

Numerous visits have been paid throughout the year to the many private Nursing and Old Persons' Homes, which are increasing in number.

These Homes are visited at least twice each year and the general conditions are observed. The comfort of the patients, adequacy of staff, fire precautions, and the fees charged are noted at each inspection.

Many of these Homes are serving a very useful purpose by relieving the congestion of hospital beds, particularly in the case of old persons who are not actually bedridden, but because of difficult housing or relative relationship are better suited for residence in one of these Homes. In the main, a good standard of kindly care is provided.

ENVIRONMENTAL HYGIENE AND SANITARY ADMINISTRATIONS.

This report deals with routine duty but it does not deal with the complete range of the County Health Inspector's duties. Many new developments, for example, use of detergents and toxic sprays, have side effects on public health.

In the absence of a more suitable Officer the C.H.I. has been appointed to deal with the technical side of the fleet of 96 cars owned by the Department.

1. Milk and Dairies.

(*a*) *Sampling for the Detection of Tubercle Bacillus.*

During the year the Biological Milk Sampling Scheme was modified to some extent. Previously we had sampled all farms at intervals of nine months, but owing to the greater risks in milk from Accredited and non-designated herds, it was decided to intensify sampling in this group to once every six months, whereas Tuberculin Tested and Tuberculin Tested (Attested) herds were put on a twelve monthly sampling basis. We still consider it important to sample these latter herds as, although " T.B. Positives " are rare, brucella abortus is by no means uncommon. During the year the tubercle organism was found in milk from a Tuberculin Tested (Attested) herd and as a result a cow was slaughtered under the Tuberculosis Order. The following table shows the result of biological milk sampling during the year and for the purpose of comparison, for the four preceding years.

Table 24.

Year	Total No. of Completed Tests	Non-Designated			Accredited			Tuberculin Tested		
		Neg.	Pos.	%	Neg.	Pos.	%	Neg.	Pos.	%
1948	823	559	14	2·44	234	16	6·40	—	—	—
1949	765	462	13	2·74	164	12	6·81	113	1	0·88
1950	1,161	513	23	4·41	167	11	6·18	447	—	—
1951	1,224	442	16	3·49	173	10	5·46	567	3	0·53
1952	1,264	574	16	2·71	166	11	6·21	471	1	0·21

As a result of these positive samples during the year the following animals were removed from farms under the Tuberculosis Order, 1938, or sent for slaughter during the period between the taking of the sample and the Veterinary inquiry :—

One cow was slaughtered from a Tuberculin Tested herd, ten from Accredited herds, and twelve from non-designated herds. Eight suspicious animals were removed from positive herds of which seven were slaughtered.

The practice of taking biological samples at the farms where the milk is produced has been continued. This simplifies the work of tracing infected animals at the farm and it has been found from experience that where biological samples are taken at retail dairies, there is always doubt as to the origin of the milk, especially at dairies where the milk is bulked.

The three-cornered liaison scheme which exists between the Divisional Veterinary Officer, the District Medical Officer, and the County Medical Officer, has been successfully continued. Positive samples are immediately reported to both the District Medical Officer and the Divisional Veterinary Officer, the former for his powers for stopping or diverting the milk for pasteurization and the latter for the subsequent herd investigation and removal of infected animals under the Tuberculosis Order, 1938. The fact that the County Council carries out this biological sampling is advantageous in that a steady flow of samples to the various laboratories used can be maintained. The Divisional Veterinary Officer operates over a number of counties and it is easier for the County Health Department to keep in touch with him than would be the case for the thirty-four individual District Councils. In sampling at County level we now get over a thousand samples a year from which we can, after analysis, deduce something, whereas individual District Councils sampling on their own accord would have so few results that they would be unlikely to get any worthwhile statistics. The District Councils lose nothing by the present system because, as has been shown, the results of our samples are made known to them and we believe all in fact welcome the Scheme.

(*b*) *Brucella Infections in Milk.*

Brucella Abortus.

The five laboratories which receive our biological samples are all examining the milk not only for the presence of the tubercle organism, but also for Brucella abortus—the organism which causes contagious abortion in cattle and undulant fever in man. The following table shows the number of brucella positive milks in 1952 :—

TABLE 25.

Designation	No. of Completed Tests	Results		Percentage of Positive Samples
		Positive	Negative	
Tuberculin Tested . .	461	31	430	6·72
Accredited . . .	169	14	155	8·28
Non-designated . .	573	58	515	10·12
Pasteurized . . .	25	—	25	—
Totals	1,228	103	1,125	8·39

The memorandum which was to have been issued by the Ministry of Health to clarify the Brucella question has not materialized. Responsibilities rest with the District Medical Officers of Health who may, under the Milk Regulations, 1949, stop or divert brucella infected milk for pasteurization. The relatively high percentage of positive samples obtained as shown in the above table, would indicate that while much of the County's milk supplies are in fact being pasteurized, considerable quantities of infected raw milk must be consumed.

Unfortunately undulant fever is not a notifiable disease and while it appears that the incidence of the disease is low owing to the fact that few cases come to our knowledge, it is possible that there are many " missed " cases in the form of pyrexias of unknown origin which are not diagnosed as being due to the abortus organism. The only answer to brucella infected milk would appear to be universal pasteurization.

Brucella Melitensis.

During the year there was one case where Brucella Melitensis was isolated from a herd in the county. The infected cow was traced and was slaughtered under the Melitensis Order. No undulant fever cases were reported in people who had consumed the milk, the bulk of which was being sent for pasteurization.

(c) *The Supervision of Pasteurizing Plants.*

The County Council, as Food and Drugs Authority, licences and supervises pasteurizing plants in all districts with the exception of Watford Borough and the City of St. Albans, which are separate Food and Drugs Authorities.

Pasteurized milk has to comply with the phosphatase test to ensure that it has been subjected to sufficiently high temperature for the specified period of time which will ensure the destruction of pathogenic organisms. A modified methylene blue test is also used to determine the cleanliness or otherwise of pasteurized milk.

The following table shows the results of sampling from plants during the year.

TABLE 26.

	No. in County	Phosphatase Test			Methylene Blue Test		
		No.	Failed	%	No.	Failed	%
H.T.S.T. Plants . . .	6	373	5	1·34	357	1	0·28
Batch Holder Pasteurizers .	13	627	25	3·99	591	5	0·85
Batch Holder Plants coupled to obtain continuous flow .	1	82	2	2·44	76	—	—
	20	1,082	32	2·96	1,024 *	6	0·59

* 58 of these samples were not subjected to the methylene blue test owing to atmospheric temperatures being above 65° F.

The High Temperature Short Time plant subjects milk to a pasteurizing temperature of not less than 161° F. for a period of not less than fifteen seconds ; the batch holder heats and retains the milk at a temperature between 145° F. for not less than thirty minutes, and a modification of the batch holder subjects the milk to the same time/temperature treatment as the holder plant but the operation is controlled automatically to enable a series of holding compartments to be filled and emptied so that the process is continuous.

The County Health Inspector visits each pasteurizing plant at least once a month and special investigations are carried out if failing samples are reported. The County Sampling Officers visited each plant at least once a week and during the year took 981 samples. 225 visits were made by the County Health Inspector to the various plants and a further 144 samples, many of them experimental, were obtained in addition to those taken by the Sampling Officers.

It will be seen from the table that once again the lowest percentage of failing phosphatase samples came from the High Temperature Short Time

plants. These plants are mainly automatic and technically it should be difficult to produce a failure. At the same time, however, mistakes can occur mainly because of such things as faulty thermometers which result in incorrect treatment temperatures, the inaccurate setting or non-functioning of flow diversion valves and the accidental mixing of raw milk with the treated product. Batch holders are more susceptible to the human element. They are usually manually operated and it is easy for them to be emptied before the statutory holding time has been completed. The outlet valves to the holders can also leak into the finished milk section of the plant, and this again accounts for an occasional failure unless precautions are taken.

Generally the methylene blue sample results from plants were very satisfactory. Under the Regulations governing the sampling of pasteurized milk, in those instances where the atmospheric temperature exceed 65° F. after the sample has been obtained and before it is tested, the test is deemed to be void. This is owing to the undue effect which the warm atmosphere will have on the sample before it can be tested and until a better test is devised which will make allowances for varying atmospheric temperatures during sampling, this state of affairs will have to be accepted.

(*d*) *Milk in Schools Scheme.*

All School Departments including Day Nurseries and Nursery Schools continued to be supplied with pasteurized or tuberculin tested milk. The following table gives the proportion of the various grades of milk used. Figures in brackets represent the corresponding figures for 1951.

TABLE 27.

Dairies	Grade of Milk	School Departments	Nurseries
51	Pasteurized . . .	342 (343)	42 (42)
4	Tuberculin Tested .	6 (8)	— (—)

Sampling.

Schools and Nurseries are visited by the County Sampling Officers and the milk supplied by each individual dealer is tested at least twice a term. The larger suppliers of milk to schools are sampled more frequently. The following table shows the results of samples taken.

TABLE 28.

	No. of Samples	Phosphatase Test		Methylene Blue Test	
		Pass	Fail	Pass	Fail
Pasteurized . . .	371*	365	6	330	6
Tuberculin Tested .	27	—	—	25	2
Total	398	365	6	355	8

* 35 of these samples were not subjected to the methylene blue test owing to high atmospheric temperature.

The above results can be classed as being reasonably satisfactory. As far as the phosphatase results are concerned some of the failures were probably due to dairies which admitted to supplying raw Tuberculin Tested milk instead of pasteurized. The samples being raw milk, naturally failed the phosphatase test. The eight methylene blue failures out of a total of 355 samples can also be considered as quite satisfactory. It must be remembered that normal milk sampling procedure is to take samples at the dairy or during distribution and not after delivery has actually taken place as is the case with school milk samples. The test can be adversely affected if milk is stored in schools in warm places or if it is left out in the sun for a considerable time before being taken into the building. Efforts are made to see that milk is in fact properly stored in schools and that it arrives at a reasonable time.

Throughout the year liaison has been maintained with the local authorities and the Ministry of Agriculture and Fisheries where milk samples have failed the prescribed tests. If the milk is pasteurized and a failure is recorded then it is possible for this Department to investigate directly at the plant where the milk is processed, provided it is within the licensing area of the County Council. Information regarding other pasteurized milk failures are forwarded to the licensing Authority for the plant in question. Where a raw Tuberculin Tested milk fails the methylene blue test, the Area Representative of the National Milk Testing Service is informed and also the County Agricultural Executive Committee. This enables the farm to be visited and samples to be taken to detect any trouble which may have arisen in production methods or distribution.

In some cases it is found that where a sample fails, the fault lies not at the farm where the milk is produced or the dairy where it was pasteurized, but at the retail dairy stage where bottling was carried out. The District Councils are responsible for registering these retail dairies and follow-ups are made whenever trouble is suspected.

(e) School Canteen Milk.

Canteen milk is supplied to the schools on a contract and only pasteurized milk is accepted. Arrangements have been made to include canteen milk in the general sampling scheme. This is not difficult as many of the suppliers of canteen milk are being regularly sampled under the Milk in Schools Scheme and in other instances, pasteurizing plants where the milk is heat-treated are also licensed by the County Council as Food and Drugs Authority. There are 331 School Canteens including Nursery Canteens. The number of samples obtained from school canteens is relatively low owing to the fact that as mentioned above, many of the sources of supply are already being sampled.

The following table shows the results of canteen milk sampled during the year.

TABLE 29.

Grade	No. of Samples	Phosphatase Test		Methylene Blue Test	
		Pass	Fail	Pass	Fail
Pasteurized . . .	45*	43	2	39	—

* Six of these samples were not subjected to the methylene blue test owing to high atmospheric temperature.

2. School Canteens.

District Councils are responsible for ensuring that food is prepared and stored in premises which comply with the standard laid down in Section 13 of the Food and Drugs Act, 1938. They have also made Bye-laws for regulating the handling, wrapping, and sale of food. Arrangements continue whereby Inspectors of District Councils visit school canteens and food preparing premises used under the School Meals Scheme. These Officers are able to proffer any advice or assistance which may be required in connection with the handling of food supplies and the equipment of premises used for such purposes.

3. Swimming Baths.

Regular sampling of those swimming baths used by County Council school children was maintained during the year. The following table shows the sampling results.

Table 30.

Type of Bath	No. of Samples	Satisfactory	Not Satisfactory	% not Satisfactory
Continuous flow (22 baths) . .	191	186	5	2·62
Fill and empty (5 baths) . .	38	34	4	10·52
	229	220	9	3·93

The continuous flow type of purification system depends on constantly circulating the water through a filtration system and sterilization is effected by the injection of chlorine. The process is continuous and automatic. The " fill and empty " type of bath is simpler in design and merely consists in filling the swimming pool with water which is changed after a given period of time has elapsed. The bacterial content will build up progressively during use if no germicidal agents are added. The bacterial growth is usually controlled by adding a hypochlorite solution to the water so that a residuum of free chlorine is maintained which assists in preventing, not only bacteria multiplying, but also algoid growths forming on the sides of the bath. Very frequent testing of the water for free chlorine is necessary, and these baths should be emptied certainly not less frequently than every three weeks, although the period may have to be shortened in the summer months.

Some baths using the continuous flow purification system have gone over to what is known as " break-point " chlorination. This is an improvement on the old methods of chlorination in that the chlorine dosage is regulated carefully to be of sufficient strength to " break down " the organic matter contained in the water and to preserve at all times a free source of chlorine to attack bacteria which may be introduced by bathers. With this method of chlorination the alkalinity of the water must be carefully adjusted to obtain the best results.

4. New Housing.

The following table shows the position regarding new housing provided by District Councils in the County from the 1st April, 1945, to the 31st December, 1952. It is taken from the Ministry of Health Housing Return.

TABLE 31.

	Permanent Housing		Temporary Housing Completed
	No. under Construction	Completed	
BOROUGHS.			
Hemel Hempstead	84	482	50
Hertford	119	348	50
St. Albans	327	1,557	109
Watford	328	1,893	100
Total—Boroughs	858	4,280	309
URBANS.			
Baldock	54	285	—
Barnet	98	327	100
Berkhamsted	48	248	30
Bishop's Stortford	18	477	85
Bushey	44	329	50
Cheshunt	104	520	135
Chorleywood	6	80	—
East Barnet	12	609	50
Harpenden	76	424	25
Hitchin	106	399	50
Hoddesdon	104	390	38
Letchworth	192	792	50
Rickmansworth	135	610	100
Royston	26	196	—
Sawbridgeworth	20	97	10
Stevenage	70	253	20
Tring	10	108	—
Ware	18	266	13
Welwyn Garden City	46	546	150
Totals—Urbans	1,187	6,956	906
RURALS.			
Berkhamsted	26	100	—
Braughing	12	366	—
Elstree	104	916	100
Hatfield	169	564	66
Hemel Hempstead	63	322	35
Hertford	48	257	—
Hitchin	106	422	38
St. Albans	90	747	6
Ware	26	376	—
Watford	26	338	50
Welwyn	53	129	46
Total—Rurals	723	4,537	341
TOTAL—COUNTY	2,768	15,773	1,556

This table does not show the housing development in the New Towns within the County boundary. The following table shows the number of houses completed in the New Towns at the 31st December, 1952.

TABLE 32.

	No. under Construction	Completed
Hatfield	450	219
Hemel Hempstead	1,259	1,579
Stevenage	644	1,035
Welwyn Garden City	424	414
TOTAL	2,777	3,247

5. Refuse Disposal.

Provisions exist under the Hertfordshire County Council Act, 1935, for the County Council and the District Council concerned to control the tipping of refuse collected within the boundary of one county district and disposed of in another county district. This ability to control " imported refuse " is of great value when taking into consideration the proximity of the County to the heavily built-up areas of Greater London. In London itself there is a considerable refuse disposal problem in that there is no land available to enable internal tipping or disposal arrangements to be considered on a large scale. Much of London's refuse has to be barged down the river to large disposal areas in the Essex Marshes, or else it has to be exported by road or rail to tipping sites outside the Greater London area.

As Hertfordshire has many mineral workings there are numerous excavated sites in the County which are suitable for the disposal of household refuse, and therefore it is not unexpected that a considerable quantity of London's refuse finds its way here. Without the control on tipping which can be exercised under the Hertfordshire County Council Act it is fairly obvious that complications would arise. The conditions imposed enable refuse to be dealt with in a manner designed to cause the minimum nuisance and at the same time to ensure that land sterilized by mineral workings is brought back into cultivation. It is here that liaison between the Health Department and the County Planning Department is so essential.

During 1952 303 visits were made by the County Health Inspector to County Council controlled refuse tips. At the time of writing this report there are six controlled tips licensed under the Hertfordshire County Council Act for the reception of domestic refuse, two receive destructor clinker and screenings, nineteen receive only inorganic and non-putrescible materials, while a site is set aside for the reception of acetylene waste.

In addition to the above tips, an experiment is being carried out in land reclamation in which household refuse is being tipped and burned, the residue from this being bulldozed over low-lying land in order to raise the level and produce a fertile area which can be grassed over or cropped at a later date. The land being reclaimed is poor scrub which has no agricultural value as it stands.

From time to time our views are sought on the advisability of tipping various types of industrial waste on the licensed sites in the County. The very nature of the consents which are issued to control tipping often precludes the reception of such materials and we have to be satisfied on a number of points before favourable consideration is given. Many of the gravel workings in which refuse is deposited are " wet " pits and certain types of chemical waste might adversely affect the water in them. On the other hand, many " dry " pits have to be watched with care to see that no dangerous liquids " leak out " and gain access to watercourse and underground water supplies. The whole problem of the disposal of factory refuse from built-up areas is steadily growing more acute and firms would be well advised to make sure that there are " safe " tipping grounds within easy reach for their waste products before developing their factories.

The rising popularity (mainly for economic reasons) of road transport over rail means that an ever-growing assortment of vehicles carrying waste materials of varying degrees of offensiveness is to be seen on our already heavily burdened roads. The private motorist will have his own views on the increase in heavy traffic, but all sections of the community will be affected if the use of inadequate and ill-designed vehicles means that refuse, either of a solid or liquid kind, is spilled on our highways. The provision of adequate legislation and its efficient enforcement is the only likely deterrent to offenders who would otherwise litter our roads with every conceivable kind of rubbish.